IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

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| CENTRAL VALLEY AG COOPERATIVE and CENTRAL VALLEY AG COOPERATIVE HEALTH CARE PLAN, Plaintiffs, | CASE NO. 8:17CV379 |
| vs. | D E P O S I T I O N |
| DANIEL K. LEONARD, SUSAN LEONARD, THE BENEFIT GROUP, INC., ANASAZI MEDICAL PAYMENT SOLUTIONS, INC., d/b/a/ ADVANCED MEDICAL PRICING SOLUTIONS, CLAIMS DELEGATE SERVICES, L.L.C., and GMS BENEFITS, INC., Defendants. | |

* * *

DEPOSITION OF JEAN REED taken before Tina M. Nelson, Registered Merit Reporter and General Notary Public in and for the State of Nebraska, at 10:01 a.m. on February 22, 2019, at 10050 Regency Circle, Omaha, Nebraska, taken on behalf of the defendant, TBG, pursuant to the Federal Rules of Civil Procedure and the within stipulations.

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**EXHIBIT 2**

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Also present: Mr. Rick Smithpeter

I N D E X

E X H I B I T S

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(Deposition Exhibits 190 and 191 were marked.)

JEAN REED,

having been first duly sworn,

was examined and testified as follows:

DIRECT EXAMINATION

BY MR. THALKEN:

Q. Good morning, Ms. Reed; we met briefly before the deposition. My name is Tim Thalken, I represent The Benefit Group in this lawsuit. Would you please state your full name for the record.

A. Jean Marie Reed.

Q. What is your date of birth?

A. 7-24, 1952.

Q. Where do you live?

A. Sioux Falls, South Dakota.

Q. And where do you work?

A. Self-employed, Impact Consulting.

Q. Does Impact Consulting have any employees?

A. Just myself.

Q. How long has Impact Consulting been in operation?

A. It was established in 1990.

Q. And what type of consulting do you do?

A. The majority of my consulting work is in

health benefits, managed care. And then in addition to that, I do some consulting on strategic planning, marketing, communications and advertising.

Q. Have you ever worked for a third-party administrator before?

A. Yes, I have.

Q. Go ahead. Who?

A. Avera Health Plans; I was the president of Avera Health Plans for four years.

Q. And that's a third-party administrator?

A. We functioned as a third-party administrator. They were licensed as a -- as an HMO in South Dakota, Iowa and at one point in time in Nebraska and in Minnesota.

Q. And what did you do as president of Avera Health Plans, what was your responsibility?

A. Oversaw all of the operations essentially, had responsibility for all of the staff, all of the financials, claims processing.

Q. Did you interact -- or have you interacted at all with The Benefit Group before?

A. I have not.

Q. In this case did you ask for some information through Kutak Rock to obtain from

The Benefit Group?

A. Essentially they sent information to me.

Q. Okay. Are you aware of any situation where The Benefit Group didn't cooperate in that process?

A. Not that I'm aware of.

Q. Okay. In front of you is Exhibit 190. Is that a copy of your expert report in this case?

A. Yes, it is.

Q. And just, I guess, to clarify, Exhibit 190 also includes -- looks like there's a spreadsheet on the back for a date of service report --

A. Correct.

Q. -- correct?

A. Correct.

Q. And did you prepare this report?

A. I did.

Q. Have you made any revisions to the report --

A. Have not.

Q. -- since -- since January 29 --

A. Have not.

Q. -- 2019? Okay. And January 29, 2019, is the date of your report --

A. Correct.

Q. -- correct? Okay. When were you hired

to provide consulting services in this case?

A. Actually those conversations started July of 2017. Contract was signed September of '17.

Q. Okay. And who is the contract with?

A. I would have to actually look at the contract itself to give -- to give you the exact name because all of the work that I've done has been predominantly with Kutak Rock.

Q. Okay. Do you know if your agreement was with Kutak Rock or was it with Jackson Lewis or CVA directly?

A. It was with CVA directly, yeah.

Q. Have you issued invoices --

(A discussion was held off the record.)

Q. So I think where we left off was, you think your engagement is with CVA --

A. Yes, it is.

Q. -- directly.

A. Yep.

Q. Okay. And then you provided me an example of -- or excuse me, with Exhibit 191?

A. Correct.

Q. What is that document?

A. That actually is an invoice of the hours through February 19th of 2019.

Q. Okay. And at the top it says Jackson Lewis invoice?

A. The way that it had been set up was that I would submit the hours and any work that I did for those -- for those hours directly to Jackson Lewis, and then they would pass that on to the client.

Q. Okay. And did you issue regular invoices throughout?

A. Did not. This is the first invoice.

Q. Okay. The first entry on Exhibit 191 says C-o-n call KB. Do you --

A. Yes.

Q. -- know who KB is?

A. Kathleen Barrow.

Q. Okay. August 9th, 2017, C-o-n call HP.

A. That is with Heather --

MS. BAUMERT: Panick.

A. Panick.

THE WITNESS: Thank you.

Q. Do you know how to spell her last name?

MS. BAUMERT: I do. P-a-n-i-c-k.

THE WITNESS: Thank you.

Q. Is that a Jackson Lewis attorney?

MS. BAUMERT: Yes.

A. Yes.

Q. Then there's one on December 18, 2017, conference call KR?

A. Kutak Rock.

Q. Okay. January 15, 2019, meeting JL.

A. Jackson Lewis.

Q. Okay. So in July -- there's an entry here July 8, 2017, for one nonbillable hour, conference call. What's the -- why is it a nonbillable hour?

A. It was essentially when we talked about the engagement. And at that point Kathy and I talked about what would be involved, is it something that I'd be interested in doing. She talked about me -- about my experience to see if it was something that she thought I could assist with.

Q. And what was she asking you to assist with?

A. She was asking me to assist with reviewing the claims, my experience in being able to go through the documents, validate the accuracy of the billing, being able to give recommendations on what payments should be within the marketplace, my knowledge of the marketplace and how that

knowledge had been gained.

Q. Did you know Ms. Barrow before this engagement?

A. We had worked together on another -- in another professional capacity for another client that she was serving at that time, that she and I both served at that time.

Q. And what was that engagement?

A. That engagement was Jackson Lewis has a client that they were serving at that point in time, State of South Dakota.

MS. BAUMERT: I'm probably going to have to object on attorney-client privilege with regard to that --

THE WITNESS: Okay.

MS. BAUMERT: -- relationship.

MR. THALKEN: Yeah.

MS. BAUMERT: I don't know anything about it.

Q. Yeah. And I don't need to know --

A. Okay.

Q. -- who or --

A. Okay.

Q. I just kind of need big picture.

A. Yeah. We both had a professional

relationship with a client and became contacts in that regard.

Q. And did you serve as an expert in that capacity?

A. No. I have an ongoing client relationship.

Q. Consulting --

A. Consulting relationship.

Q. Doesn't have to do with litigation?

A. No, not at all.

Q. Have you ever testified before as an expert in court?

A. I have in one other situation. That's been ten-plus years ago.

Q. What case was that?

A. It was a case in Wisconsin where there was a -- a transplant that had been denied.

Q. And in what capacity did you serve as an expert?

A. I served as an expert as a former health plan CEO, explaining the process that a health plan would go through to review complicated medical cases and why those kinds of cases could legitimately be denied.

Q. Have you ever been excluded as an expert witness in any case?

A. Have not.
Q. Have you ever given a deposition before?
A. I have.
Q. How many times?
A. I would say eight or more.
Q. What type of cases?
A. Types of cases involved wrongful termination, work comp cases. Most of these were during my employment with my former employer.
Q. With Avera?
A. Yes.
Q. Any depositions as an expert witness prior to today?
A. Just the one I previously mentioned.
Q. The Wisconsin case?
A. Yeah.
Q. Okay. Exhibit 190, your expert report, are those all -- does that contain all of the opinions you intend to offer in this case?
A. It is.
Q. Do you have any opinions regarding the services that The Benefit Group provided to the plan?
A. I'm not sure I understand.
Q. Do you have any criticisms of anything

that The Benefit Group did with respect to the plan in this case?

MS. BAUMERT: Objection to the extent that exceeds the scope of the report, I suppose.

A. Yeah. I don't -- yeah, I don't know how that relates specifically to -- to the claim reviews.

Q. Well, and that's what I'm trying to understand. Are you going to offer any opinions that The Benefit Group did anything wrong in this case?

MS. BAUMERT: Objection; same objection.

A. I don't know that I can speak to that.

Q. So looking at, looks like, Page 2 of your report, at the top you say, I have been asked to opine concerning the accuracy of the claims submitted --

A. Uh-huh.

Q. -- based on the information provided and review charge amounts, to provide an opinion regarding the appropriateness of the charge amounts and to recommend a target settlement amount for these outstanding claims. For certain

claims I was also asked to review the claims and other documents to reconcile the claim amount and determine the exact amount the patient or the plan owed on the claim.

A. Uh-huh.

Q. I have also been asked to opine regarding the payment recommendations by AMPS/CDS for claims of plan participants during plan years 2015 and 2016. Did I read that correctly?

A. Correct.

Q. And is that the scope of what you did in this case?

A. Yes.

Q. Page 3 of your report, fourth bullet down -- and this, I believe, is -- is your qualification -- under the heading, Qualifications?

A. Correct.

Q. Fourth bulletpoint down says, Implemented a new hospital outpatient risk-based payment methodology for one of South Dakota's largest employers.

A. Correct.

Q. What is a risk-based payment methodology?

A. A risk-based payment methodology is a fixed payment for outpatient services, specifically

in this case it's an ambulatory payment classification system, also known as a house -- hospital outpatient prospective payment system. It's a Medicare-based payment.

Q. Is that similar to reference-based reimbursement?

A. No --

Q. How does it differ?

A. -- absolutely not at all. It's a Medicare-based system where each of the providers has a contract where they understand what it is that they're going to be paid based on a conversion factor. They know based on the -- the weight, again, a CMS weight for that specific case how much they're going to be paid for that episode of care. And the reason that it's risk based is that if the provider is able to process the payment within the defined terms, the defined time frame, then they're successful in reaching -- making -- if you will, making dollars on that case. If they exceed the expected time frame, then they lose dollars on that case. So that's why it's risk based, and that's stated in their contract.

Q. Do you have experience with reference-based

reimbursement plans?

A. In that I'm familiar with them, from that stand- -- standpoint, yes, I do have experience with them.

Q. What is your familiarity with reference-based reimbursement?

A. When I was responsible for managed care contracts within Avera, we had a couple of different providers -- or payment organizations that tried to put risk-based pricing in place within our health system. We rejected those and immediately refused to cooperate with those third-party administrators.

Q. Now, you said tried to put together risk-based pricing.

A. I'm -- I'm sorry, not risk-based but reference-based pricing. Yeah.

Q. So there were -- so there were a couple of plans or what were they?

A. TPAs.

Q. Okay. So there were a couple of TPAs, third-party administrators --

A. Uh-huh.

Q. -- who tried to implement reference-based reimbursement with Avera, and Avera rejected --

A. Correct.
Q. -- those.
A. Yes.
Q. Any other experience with reference-based reimbursement?
A. My other experience with it is knowledge of reference-based pricing in the State of Montana.
Q. Okay. What's your knowledge?
A. The State of Montana, for the state employees in Montana, uses a reference-based pricing model where they're unable to obtain a contract.
Q. Your familiarity when you were at Avera with those RBR -- I'll call it RBR --
A. Uh-huh. Okay. Yes.
Q. -- for short. Do you understand --
A. Yes.
Q. -- what that means?
A. Uh-huh, yes.
Q. When was that experience?
A. That -- that would have been -- that would have been in the late '90s to early 2000. We had -- we had experience then and then again probably in mid 2000, so maybe 2003, 2004.

Q. Do you know -- do you remember who the TPAs were that were trying reference-based reimbursement?

A. I can't say specifically who they were. I do remember one was from out of state, I don't remember the name. Both of them were from out of state, I don't remember the names.

Q. Did Avera operate in Nebraska at any point?

A. We -- yes.

Q. When?

A. Currently operate in Nebraska. And acquired -- acquired hospital and clinic -- I don't remember the year, but did acquire both hospitals and clinics in Nebraska.

Q. Which ones, if you can remember?

A. St. Anthony in O'Neill, Nebraska, and the clinics associated in O'Neill.

Q. Okay. Any others?

A. There were other hospitals that are part of a -- a part of a hospital buying group in Nebraska around the O'Neill area that we consulted with but did not actually own or manage those. And they were all independent hospitals.

Q. So earlier you mentioned Avera was, I

thought, a health plan.

A. Uh-huh.

Q. But it also owns hospitals; right?

A. Correct, hospitals, clinics, nursing homes.

Q. So when you worked for Avera, were you working for the hospitals?

A. Both. I -- I was at the health system and then also for a period of time was at the health plan.

Q. Okay. And looks like you're being paid $350 per hour?

A. Correct.

Q. Okay. And that's reflected on Exhibit 191.

A. Yes.

Q. And this is -- this shows $32,900 billed to date?

A. Through the 19th.

Q. Through --

A. Yeah.

Q. -- February 19, 2019.

A. Correct.

Q. And none of this has actually been billed though; correct?

A. Correct.

Q. All right. Page 6 of your report,

Exhibit 190, first full paragraph --

A. Okay.

Q. -- second sentence, Generally when a preferred provider organization is in a position where they represent larger employer groups collectively, they can obtain a minimum of a 20 to 25 percent discount and upwards of a 30 to 35 dis- -- excuse me, 30 to 35 percent --

A. Uh-huh.

Q. -- discount or possibly fixed reimbursement on certain procedures such as imaging or other high dollar cases if the TPA can administer the payment methodology.

A. Correct.

Q. That's -- that's part of your opinion in this case?

A. Absolutely.

Q. Okay. What is the basis for the discounts that you've listed?

A. Two different -- two different places. One would be during the time that I was responsible for negotiating the contracts for Avera, those were the types of discounts that -- that were normal, if you were, not only from -- from Avera but were representative of what payers

generally received within the marketplace, whether it was a Wellmark or it was a Dakota Care, it was Blues of Minnesota, it was United from the -- you know, the Nebraska area. Those were the types of discounts that were given, whether it was Avera or someone else.

And so -- and it depended upon the size of the employer. Obviously the larger the employer, if you were doing a direct contract, then those discounts were larger. And then when I started to do direct contracts with employers, and Avera did some of those and I've also done those on my own, you find that if there's a larger employer, again, you'll see a willingness for there to be an increase in the discount.

Q. So is it fair to say then that essentially a standard PPO agreement you would expect a 20 to 25 percent discount off billed charges; is that --

A. Correct. Yeah.

Q. But in some cases if you're larger, you might get 30 to 35 percent?

A. Thirty to 35 if you're larger. And then, again, you'll see reference later in the report that there is an opportunity for it to be even

higher than that, again, depending upon the size of the group.

Q. What do you consider to be a large employer for purposes of getting that larger discount?

A. Typically it can be a larger group if you're talking -- in our marketplace, in --

Q. Right.

A. -- this particular area?

Q. In Nebraska.

A. In Nebraska? If you're looking to say if you've got maybe 1500 to 2,000 employees that are going to be accessing and, particularly, if you can offer some sort of exclusivity or some kind of steerage to a particular location.

Q. Define steerage.

A. Steerage meaning that there is some kind of -- either it's an exclusive arrangement or there's some type of incentive for a member to use a particular facility.

Q. So, for example, an employer could say to its employees, hey, go to Bergan, you'll get a better discount or --

A. Correct. You'll have less out-of-pocket expenses.

Q. Okay. And that would be an example of steerage.

A. Correct.

Q. Now, just to make -- I think you said a larger group would be between 1500 and 2,000 employees accessing. Do you make a distinction between employees versus members of the plan?

A. Not necessarily, because it's number of people that are going to be using the services.

Q. Okay. So if you have 600 employees but with their families you have 1500 members --

A. Right.

Q. -- you would consider that a large group?

A. A larger group, yes.

Q. You also mentioned, I think, in your experience that there are direct contracts with employers.

A. Uh-huh, correct.

Q. That's different than a PPO agreement; correct?

A. Yes, it is. Yes.

Q. What is a direct contract?

A. Direct contract is a contract that exists directly between the employer and the provider.

Q. Okay.

A. So it essentially eliminates the middleman.

Q. The next paragraph on Page 6, which is the second full paragraph, you talk about reference-based pricing. And about --

A. Correct.

Q. -- four lines down you write, In no situation was a reference-based price accepted unless it was accompanied by a contract negotiated in advance.

A. Correct.

Q. Okay. Tell me about your experience with that.

A. I mentioned that there was the situation where a TPA came in and had put forward -- tried to do reference-based pricing, and there was no contract. We essentially rejected all of those -- refused -- essentially refused any claim that was presented at the hospital or a clinic. And so when that happened, obviously members were put at risk because they were then billed for the entire service. The employer was contacted and explained that they -- that because of that, they had been sold a plan that had no network and that their members were substantially at risk and the

employer was substantially at risk.

And until that employer was able to move their employees to a plan that had a network, we offered to provide -- to agree to do a short-term contract. We agreed upon a price so it really wasn't a reference price. But we agreed upon a price with that TPA to accept a specific payment. And essentially what -- because what we said to the employer is that no employer would do that to their employees because you leave the employee at such risk.

Q. Do you remember who the TPA was? I can't remember if I asked you.

A. Yeah, and I said I don't remember. I just know they were from out of state.

Q. Do you know if the TPA was using a vendor to assist them with their reference-based plan?

A. That I don't know.

Q. Do you have any experience with AMPS, Advanced Medical Pricing Solutions?

A. I don't.

Q. How was the situation resolved that you mentioned with Avera on these reference-based claims?

A. Again, we did a short-term agreement

until the -- until the employer could move their employees to an insurance organization that had a full network.

Q. And do you know who -- so they went to a PPO then?

A. They went to a PPO, yeah.

Q. Okay. And so in the interim you had a direct contract with the TPA or the employer?

A. The employer.

Q. Do you know what -- did that provide a discount to the employer?

A. Absolutely.

Q. Do you remember what percent that was?

A. I can't say specifically. I can't say specifically what it was.

Q. What's your best estimate of what the range --

A. My best estimate --

MS. BAUMERT: Objection, exceeds the scope of the report but --

A. Yeah, yeah.

Q. You can answer.

A. I don't want to guess so --

Q. You don't have an estimate of what the settlement was?

MS. BAUMERT: Objection; asked and answered, speculation.

A. I'm not going to guess.

Q. Okay. On the bottom of Page 6 you write, It is highly unusual for claims to be unresolved for two or three years after participants incurred them, as they were for the CVA plan for plan years 2015 and 2016 because so many providers rejected payment on claims under the RBR program. Did I read that correctly?

A. Correct.

Q. How many providers rejected payment on claims under the RBR program?

A. Of the claims that I reviewed -- and I believe what I sent in were the -- what did I have, 14 -- 14 claims, that I reviewed, and I viewed those as rejected claims because they were unresolved. And so that was my definition of a rejected claim.

Q. Okay. So there are 14 instances that you reviewed through your engagement?

A. Correct.

Q. And you've charged $32,900 to review those 14 claims?

A. That's not what all of that involves.

There were other things that I have done with that, so there are other things that are included in that.

Q. And what else have you done?

A. Some of it was some documents that I reviewed, other is document preparation.

Q. What documents did you review?

A. I reviewed the AMPS document.

Q. What do you mean by the AMPS document?

A. The -- I believe that's what it's called. Actually the -- this one (indicating), the --

Q. The RBR program services agreement?

A. Correct.

Q. Okay.

A. I reviewed the summary plan description, the employee summary -- the plan document and summary plan description. I also -- and then referred to that as I was going through the individual claims. And then as I was going through each one of the claims, I would then -- I pulled each of those claims and did a reconciliation on each one of those claims.

Q. Okay. Looking at Exhibit 191, most of your entries, is it fair to say, refers to claims reviewed.

A. Correct.

Q. Okay. There are some entries, for example, on January 20, 2019, where you say claim review, slash, prep, and you billed $6300 for that?

A. Correct.

Q. What prep did you do?

A. What I did there was to go back and essentially -- when I first -- the first time that I did the claim review, I had not documented all of the dates of service. And so I went back through each one of those and documented the date of service and did that in preparation for this meeting.

Q. Okay. So you did that to prepare for this deposition?

A. Correct.

Q. And then January 24, 2019, you say document prep and you billed $8,750 for that.

A. That was a combination of doing the write-up, the detail for each one of the individual claims. And part of doing that, to make sure that it was completely accurate, I went back through and essentially reworked each and every one of those claims.

Q. How did you rework each claim?

A. I explain in here how I went through the process. And so essentially with each claim I started by looking at that claim. And when I did so, I would start by making sure that the claim was accurate by looking at the billing, comparing the -- what was being billed, compared that to a CPT manual to be sure that the right codes were billed.

And then I would look to be sure that when I looked at it -- here, let me get back to my documents so I can do this a little more succinctly. So then after I took it through the CPT code, then I would go through and make sure that all of the hospital billing information was right. Oftentimes had to go back to the SPD. And then I would -- went through my individual notes and the conversations that I had, most times with Kutak Rock, relative to the recommendations that I had made. Determined the source of what generated that, did the document come directly to Kutak Rock, was it a delinquency notice that caused the contact, was it something that came from a collection agency, did it come directly from the member? So what was the source of that so that I could detail all of that in the write-up.

Q. So you have notes with your conversations with Kutak Rock?

A. And those I actually included here in the summary information.

Q. The actual notes are included or you just mean you retyped them?

A. I retyped them --

Q. Okay.

A. -- yeah.

Q. Did you have handwritten notes or what do you have?

A. Mostly just something that I wrote on the claim that said, you know, recommend 20 to 25 percent discount. Yeah.

Q. Did you prepare any -- other than this report, when you were working with Kutak did you prepare any recommendations in writing to them?

A. I did not.

Q. Okay. It was all oral communications?

A. Yes.

Q. How about any E-mails with Kutak, did you ever E-mail them?

A. What I E-mailed -- information that I E-mailed is included in the report. Yeah.

Q. But not the actual E-mails. I guess what

I'm saying --

A. Oh, no. No.

Q. Is it fair to say that the entry on Exhibit 191 for January 20 and January 24, those two entries are the time you spent preparing your expert report?

A. Yes.

Q. Did you keep any records as to how long you spent looking at any of the individual 14 claims that you looked at?

A. Yes.

Q. Okay. How would you --

A. Yeah.

Q. -- would you record that time?

A. On the -- how would I record it?

Q. Yeah.

A. Oh, I -- I keep track of the amount of time that I spend for each of my clients. Each day that I do the work for that client I record it on the specific day and the amount of -- on a calendar and the amount of time that I worked for that client. And then I would indicate also which of the claims I worked on. So if I worked on, say, a patient W.S., that first patient, I would indicate the number of hours that patient took and

have that recorded on the calendar.

Q. Okay. Did you bring that information with you?

A. I did not.

Q. Okay. But you have it available if --

A. I do.

Q. Okay. So there is a record somewhere of how much time you spent on each of these 14 claims?

A. Correct.

MR. THALKEN: And, Michaelle, we would like to see that.

MS. BAUMERT: I don't have it so --

MR. THALKEN: Well, she just said she has it.

MS. BAUMERT: But I don't think it's proper to issue the notice with a duces tecum aspect to it. We'll look into that, we can talk about it.

MR. THALKEN: Okay. She's got a record --

MS. BAUMERT: It's important to you to know how much time she spent on Willis Smith's claims, for instance?

MR. THALKEN: Yes.

MS. BAUMERT: Okay. We'll look into that. I -- I think we're going to have probably an issue.

MR. THALKEN: Okay.

Q. Well, you understand that CVA is seeking the fees that you -- that you charged the plan for consulting on these claims --

A. I --

Q. -- as an element of damage in this lawsuit; correct?

A. I understand that. I would also -- well, I can talk to Michaelle about it, because that information is included with all other information for my other clients. So it's not -- it's not segregated from -- it's not something that is held for this client and this client alone.

Q. Right. And I'm not interested in what you're doing for other clients, but you're saying there is a record of how much time you spent on each of the individual 14 claims that you --

A. Correct.

Q. -- looked at.

A. But I'm also saying that if you want to see that, there will be a certain amount of work incurred to go through and isolate that and block

all of that out with all of my other clients. And I would question whether or not that would be worth it.

Q. Okay. Page 7 of your report, the top of the page. Are you there?

A. I am.

Q. All right. In addition, and then I think it's a typo, it just says B. Should that say by?

A. Yes, uh-huh.

Q. In addition, by not having signed provider contracts in place before the RBR program was implemented, the plan costs increased at a minimum of 20 percent, up to as much as 60 percent of --

A. Yeah.

Q. -- total claim cost, for an average 45 to 50 percent of total claim cost.

A. Yeah.

Q. This figure is based on other savings reports carriers in the market provide when quoting large self-funded groups.

A. Yep.

Q. Okay. Large third-party administrators can yield over a 50 percent discount on inpatient services and a 40 to 45 percent on professional

services.

A. Uh-huh.

Q. Outpatient services will be close to the inpatient range or higher depending on the type of reimbursement in place.

A. Correct.

Q. Have I read that correctly?

A. Yes.

Q. Tell me what your basis is for saying that plan costs increased a minimum of 20 percent.

A. What I -- what I did was, if you look at the plan costs and it -- for years '15, '16 and the run-out for '17 and you look at the provider savings based on the billed charges, that reflects a seven percent discount. And --

Q. Just to -- we're talking about the CVA plan here. This is --

A. Correct.

Q. -- actual --

A. I looked at the actual claims.

Q. Okay.

A. And so that reflected a seven percent discount. So essentially the differential should have been at least, I was thinking, somewhere in that 25 percent range. So that's where I came up

with that minimum of 20. And then up to as much as 60 percent, I calculated that based on -- if you look at a typical spend for health care in inpatient and outpatient and you split that 60/40 with your inpatient claims these days being 40 [sic] percent of your total spend, and that's a ballpark average, and then your outpatient being 40 percent of your total spend. And then I essentially -- and I couldn't do that specifically with their claims to get what was their inpatient, what was their outpatient spend. I didn't take the time to do that. But I just ballparked that based on the total claims figure. And so then I applied the percentages of the -- what I see for discounts when groups are quoted. And that's how I came up with those numbers.

Q. Did you draw any distinction between hospital and facility claims versus nonhospital or facility claims when doing that analysis?

A. I did. And that's the difference here because the -- the discounts I used, the 50 percent on the inpatient and then I used 45 percent on the professions.

Q. So your -- your assumption there is that a typical plan will get a 50 percent discount on

inpatients?

A. On inpatient.

Q. And a 45 percent discount on --

A. On the professional side, yeah. And I based that on what I see groups being quoted today.

Q. So how does that accord with your opinion that if they had -- if there was a PPO in place you'd get a 20 to 25 percent discount?

A. Your -- if you have a group that's being quoted, those quotes would be based on the network that is supporting them. And that would be a PPO network that would be supporting that quote. So you have an insurance company that is giving a quote to an employer. That insurance company bases those quotes on the PPO network that is supporting it.

Q. And that would be a 20 to 25 percent discount typically?

A. It -- the quotes I have seen of late, of which there were -- when I wrote this I had just seen three quotes that had these exact numbers.

Q. Of 40 and --

A. Of 50 and 40 to 45 percent on the hospital and the professional side.

Q. Who are those quotes from?
A. The one -- I saw two from Wellmark and one from Dakota Care.
Q. How many employees does Walmart have?
A. No, no, no, it wasn't from -- Wellmark gave --
Q. Oh, Wellmark. I thought you said Walmart.
A. No, no, no. I'm sorry. Wellmark, yeah. It was from Wellmark.
Q. All right. My --
A. Yeah. No, no, no.
Q. So Wellmark quoted -- you've seen two quotes from Wellmark and one quote from Dakota Care?
A. Correct.
Q. To who are those quotes issued?
A. I -- I don't feel comfortable saying who they were issued to, but they were issued to groups within this marketplace, because I think who they were issued to is confidential.
Q. Well, you're basing your opinion on these percentages, but you won't tell me who the employer was?
A. I'm sorry, that is considered proprietary.
Q. How many employees did they have?
A. The -- one of them had 32- -- the

Wellmark, one was at 3200 employees. Another was at 1600 employees. The Dakota Care one was -- that was around the 3200 mark as well.

Q. So those employers were much larger than CVA.

A. Yes, yeah.

Q. But you're assuming that CVA would have got the same discount as those larger employers?

A. I think that if, you know -- I think that it's possible that they could have gotten that same kind of discount.

Q. Do you know?

A. I can't say specifically, but I do think it's possible.

Q. It's possible they could have got less than that discount.

A. It is possible.

Q. Do you know how many balance bills CVA had to negotiate?

MS. BAUMERT: Objection, exceeds the scope of the report.

A. I don't.

Q. You looked at a total of 14 claims?

A. I reviewed specifically 14 claims.

Q. And how -- how many employees did the

plan have?

A. I don't know the -- I don't know the exact number.

Q. More than 500?

A. Yes, yep.

Q. And you're looking over a period of two years, 2015 and 2016?

A. Correct.

Q. And maybe it's not accurate to say claims, it's 14 patients.

A. 14 patients, correct.

Q. Is that --

A. Yeah, because there were multiple claims with -- yeah, there were multiple claims for these patients.

Q. Based on your review, did you determine whether the claims were submitted accurately?

MS. BAUMERT: Objection to form of the question. If you understand the question, you can answer it. If you don't understand it, you can tell him.

A. Your question to me is, were the claims submitted accurately from the providers?

Q. Yes.

A. In -- in most cases there -- there was --

there were a couple of situations where I suggested that Kutak Rock go back and get additional information.

Q. And is that what you mean on Page 7 of your report under C, Methodology, where it says, I reviewed claim submissions for accuracy and plan documents to determine if claims being filed were for covered benefits and whether claims were submitted accurately?

A. Correct.

Q. You're talking about the provider submitting claims.

A. Correct, yes.

Q. And you found a couple situations where you thought you needed some more information.

A. Correct, yep.

Q. Did you determine in those situations whether the claims were submitted accurately?

A. I did not always see the back-end process so I don't know the answer to that.

Q. Okay. Was there ever any information that you requested that you were not provided?

A. Not to my knowledge.

Q. Okay. So let's look at Page 9 and we'll kind of look at some individual patients.

A. Okay.

Q. The first one is patient W.S., is how you have it listed?

A. Uh-huh.

Q. And then let's go to the second paragraph under 1 there, four lines down says, I determined the rates being charged were over market for the services being provided.

A. Yep.

Q. So you determined that the hospital was overbilling for the services it provided to W.S.; correct?

A. Right.

MS. BAUMERT: Objection, form of the question.

Q. And you recommended that the Advanced Imaging MRI be lowered by 60 percent.

A. Uh-huh.

Q. Is that yes? You have to say yes or no for --

A. Yes --

Q. -- the court reporter.

A. -- I did, uh-huh. Sorry.

Q. No problem. And then you recommended that Saunders Medical Center be discounted at 50

to 55 percent; correct?

A. Correct.

Q. And you recommended negotiating a 60 percent discount and settling for 50 percent with Bryan --

A. Correct.

Q. -- correct?

A. Correct.

Q. And do you know what the result of your recommendations were, do you know if they were accepted by the hospitals on patient W.S.?

A. I -- I do not.

Q. And then look -- well, looking back at your report on the date of services report --

A. Uh-huh.

Q. -- that's attached to Exhibit 190, is this a list of all the individual claims that you looked at for each patient?

A. Yes, it is.

Q. Okay.

(Deposition Exhibit 192 was marked.)

Q. Ms. Reed, I'm handing you what's been marked as Exhibit 192. And I'll represent to you this is a document that was produced to us in discovery by CVA.

A. Okay.

Q. I'm going to refer you to Page 4 of Exhibit 192. There's an entry for plan participant for Willis Smith. Do you see that?

A. I do.

Q. Is that W.S.?

A. It is.

Q. Okay.

MS. MITCHELL: Tim, do you have a Bates range for this document?

MR. THALKEN: No. This is -- this is the attachment to an interrogatory answer, I believe.

MS. BAUMERT: Attachment A, yeah.

MR. THALKEN: Yeah, Attachment A and B and then -- I think I E-mailed it to you earlier.

MS. MITCHELL: Great. Thanks. Sorry.

Q. So at least with respect to Exhibit -- excuse me, with respect to Patient 1, Willis Smith, you don't know whether this is accurate as to what the final settlement was with him? You weren't involved in the back-end, as you put it?

A. I was not.

Q. Okay. But you would expect a settlement of, for example, 60 percent on the Advanced Imaging?

A. Correct.

Q. Okay. And you would expect that Saunders County would accept 50 to 55 percent?

A. Correct.

Q. And you would expect that Bryan would accept a 60 percent discount.

A. Yes, somewheres close to that for all of them.

Q. Patient Number 2, look at Page 10 of your report. This is patient R.G.?

A. Uh-huh.

Q. And then if you would refer back to your date of service report under Patient 2 --

A. Yes.

Q. -- the billed charges on Patient R.G. are $239.56?

A. Yes. Okay.

Q. Okay. And you recommended a 20 to 25 percent discount off that $239 bill?

A. I did.

Q. How much time did you spend reviewing that bill?

A. I would not have spent much time reviewing that bill.

Q. Do you think you spent more than 15 minutes reviewing it?

A. I did -- I would have because of the information -- because of how the information came in.

Q. Have you completed your answer or --

A. Yes.

Q. Okay. So you're recommending a 25 percent discount on a $239 bill.

A. Uh-huh.

MS. BAUMERT: I think you have to answer yes. Sorry.

A. Yes.

Q. So that would be a savings of about $60 off that bill?

A. Yes.

Q. You charged more than $60 to review this, didn't you?

A. Yes.

Q. And then a law firm, Kutak Rock, also assisted you with this?

A. I would have given that recommendation to them, yes.

Q. So Kutak Rock billed some time to resolve this -- to try to get a $60 discount?

A. I would assume so.

Q. Would you agree that the fees that you charged and that Kutak charged exceeded the amount of savings that you ultimately achieved on this claim?

MS. BAUMERT: Objection to the form of the question, calls for speculation, exceeds the scope of the report. You can answer if you understand.

A. Every time that something was done, it was really done for the best interest of the member and for -- for the employer. That was our intent.

Q. So even -- so you could have spent $10,000 consulting on this claim that saved $60 and that would have been in the best interest?

MS. BAUMERT: Objection to the form of that question and also exceeds the scope of the report, speculation.

A. No, that was not the point.

Q. Okay. Well, you're saying whatever you did was in the best interest of the member; right? Is that -- whatever you did was in the best

interest of the member?

A. That was always our intent was -- was to do what was right for the member and for the employer.

Q. What about the plan, did you try to do what's in the best interest of the plan?

MS. BAUMERT: Objection to the form of the question.

A. We were --

MS. BAUMERT: Exceeds the scope of the report.

A. Yeah.

MS. BAUMERT: You're trying to make distinctions between employer and plan.

A. Yeah.

Q. What's your answer?

A. To me the employer and the plan are one in the same.

Q. Okay. The work you did in reviewing these -- these 14 patient claims -- again, I don't want --

A. Yeah.

Q. -- I don't want to suggest that it's only 14 claims, but the claims of these 14 patients, is that essentially the same work that AMPS was

supposed to be doing for the plan?

MS. BAUMERT: Objection; exceeds the scope of the report, speculation, form.

A. I don't know.

Q. Well, wasn't AMPS reviewing claims to determine what amount should be paid on them?

A. I don't know.

MS. BAUMERT: Objection; form, speculation and exceeds the scope of the report.

Q. You don't know what AMPS was doing?

MS. BAUMERT: Same objections.

A. Not specifically.

Q. So then you have no criticisms of anything that AMPS did in this case; correct?

A. I -- yes, I do have criticisms of that process.

Q. But you don't know what they were doing, so what's your criticism based on?

A. My criticism is based on what I -- what I read in the document, and that is that there was balance billing to the member.

Q. And how -- how is that a criticism of AMPS?

A. It's a criticism of the process in that if there were contracts in place, there would be no balance billing to the member. So that is really more related to the reference-based pricing.

Q. You don't like reference-based pricing.

MS. BAUMERT: Objection; form, exceeds the scope of the report.

A. Reference-based pricing is an unfair practice to a -- to an employer and to a member because -- and to a provider. All the way around, it puts everyone at risk in that a provider doesn't know what they're going to be paid, an employer does not understand what their exposure is for their health insurance expenses, and it puts a member at risk to be balance billed.

Q. So if an employer entered into a contract for a reference-based reimbursement system that authorized balance billing, would you say that's a breach of its duty to -- to the plan?

MS. BAUMERT: Exceeds the scope of the report, speculation, form.

A. It would strictly be an opinion, and it's not -- it would be a judgment.

Q. That's what I'm asking for.

A. Yeah. It would be a judgment --

MS. BAUMERT: Same objections.

A. -- and I'm not going there.

Q. You're not going to answer?

A. I'm not going to make that judgment.

Q. Well, you reviewed the RBR program services agreement, didn't you? It's one of the documents earlier you said you looked at?

A. I did, I did review that.

Q. Didn't CVA sign that document?

MS. BAUMERT: Objection; form, scope, exceeds the scope of the report.

A. Yes, they did sign it.

Q. Was that a mistake on CVA's part to sign the RBR program services agreement?

MS. BAUMERT: Same objections; exceeds the scope of the report, speculation, form.

A. Yeah.

THE REPORTER: Excuse me? You said yeah?

THE WITNESS: Oh, I'm sorry.

MS. BAUMERT: Were you saying yeah to you agree with my objections --

THE WITNESS: No.

MS. BAUMERT: -- or, yeah, you --
THE WITNESS: Yes, I agree with her objection.
MR. THALKEN: Well --
MS. BAUMERT: Maybe you should read back the question.
MR. THALKEN: -- you're not a lawyer, so I'd --
THE WITNESS: Yeah, exactly.
MR. THALKEN: -- like you to answer my question and not -- and not agree with her objection.
MS. BAUMERT: I didn't think she really intended --
THE WITNESS: Yeah.
MS. BAUMERT: -- to do that.
THE WITNESS: No, I did not.
MS. BAUMERT: We just want to clarify the answer to the question, so maybe she should read back the question.
MR. THALKEN: Yes.
THE WITNESS: So could you read back the question for me? Thank you.
MS. BAUMERT: She's typing.
(The last question was read by the court

reporter.)

MS. BAUMERT: All the same objections. You can go ahead and answer if you have an opinion.

A. I don't know the answer to that.

Q. But it would be a mistake for an employer to offer any program -- or excuse me, to offer any reference-based reimbursement program in your --

MS. BAUMERT: Same objections; exceeds the scope of the report, speculation, form.

A. Again, I don't -- I'm not going to speculate on that.

Q. So you have no opinion as to whether an employer should ever enter into a reference-based reimbursement agreement.

MS. BAUMERT: Same objections, asked and answered.

A. I don't believe it is a fair option for employees.

Q. And so if an employer entered into an agreement, a reference-based reimbursement agreement, that would not be a fair option to the employees in your view.

MS. BAUMERT: Same objection;

exceeds the scope of the report, form, foundation, speculation.

A. I think I've answered that question.

Q. I don't think you have.

A. I -- I believe I have. I think it's -- my opinion is it's -- it is -- it is -- it's not a practice that is seen in this market. And my experience in working with employers, if they understand that is what is going to happen to their employees, it's not a plan they would choose.

Q. Understand what is going to happen to the employees?

A. That they're going to be balance billed.

Q. So if an employer was advised that employees were going to be balance billed and still entered into an RBR services agreement, would that be a mistake by the employer?

MS. BAUMERT: Exceeds the scope of her report --

THE WITNESS: Yeah.

MS. BAUMERT: -- speculation, foundation, form.

THE WITNESS: Yeah.

A. And, again, I -- I can't speak to that because that employer in that situation needs to

make their own decisions.

Q. And CVA made a decision here, didn't it?

A. I don't know that.

MS. BAUMERT: Objection; exceeds the scope of the report, speculation.

MR. THALKEN: Exceeding the scope of the report is not an objection.

MS. BAUMERT: It actually is; it exceeds the scope of her report.

Q. She has given opinions that RBR is not appropriate in this market; is that correct?

A. That's correct.

Q. Okay. But CVA entered into an RBR program services agreement.

MS. BAUMERT: Same objections.

Q. Didn't it?

A. They did. And, again, I can't speak to the specific circumstances of that.

Q. Okay. Page 11 of your report, Patient 3 which is patient J.K.

A. Uh-huh.

Q. And is that listed on your date of service report as well under J.K.?

A. Page 11. Patient 3; right?

Q. Correct.

A. Oh, okay. Yes.

Q. So -- and then I want to refer you to Exhibit 192 which is the --

A. Okay.

Q. -- interrogatory answer. On Page 2 of Exhibit 192 at the bottom, there's an entry for a patient Jonathan King?

A. Uh-huh.

Q. Is that J.K.?

A. It is.

Q. Okay. Tell me what you learned about patient J.K.

A. Jonathan King, in addition to the information that is -- that is written there, he had -- what was sent to us was that the entire balance for the claims that we removed were a number of lab tests that were due to a transplant. It was a bone marrow transplant. There was a collection notice that was sent that reflected the total amount that was due.

The -- one of the things that we did not have was the transplant agreement. And without that transplant agreement, we were unable to tell whether or not those lab tests should have been included within the transplant period, which

is -- which is typical that lab tests would be covered within a transplant period. But without that agreement, we weren't able to tell that.

Q. And this dispute, as I look at Exhibit 192, is over $986?

A. Uh-huh.

Q. Is that a yes?

A. Yeah. Yes, it was.

Q. Okay. Do you know how much time you spent reviewing this file?

A. I can't say specifically how much time I spent on it. I do know that he had -- yeah, again, I don't know the specific amount of time. I do know that I went back through all of the claims trying to determine whether or not we could find the transplant, the original transplant claim to match the transplant period with the billing on the labs so that we could try to avoid having to pay the billing at all.

Q. And in looking at Mr. King's claim you write, I determined the rates being charged were over market for the services being provided?

A. Uh-huh.

Q. Is that a yes?

A. That's a yes. Yes.

Q. So the hospital was overcharging the plan; correct?

A. For lab services, yes.

Q. And you recommended a 35 percent discount?

A. Correct.

Q. But it looks like on Exhibit 192 that the plan just paid the full amount, $986.

MS. BAUMERT: Can you give us a reference to what you're talking about?

MR. THALKEN: Sure, Page 2 of Exhibit 192, Jonathan King.

THE WITNESS: Okay.

Q. It says amount paid by CVA --

A. Uh-huh, right.

Q. -- 986?

A. Right.

Q. So they just paid the full bill.

A. Yes. If they were unable to get the provider to agree to the requested amount, then, yes, they would have to pay more.

Q. I want to go back to Number 2 on your report again, Page 10. Sorry. Patient R.G.

A. Okay.

Q. It says, The claim was sent to his current health provider instead of TBG.

A. Correct.

Q. So the providers -- or the provider sent the bill to -- didn't send the bill to TBG originally; is that accurate?

A. I can't say that for sure because that information was provided -- that information was provided by -- he sent that in -- yes, he sent that in in a note that -- the note that he sent requesting assistance. So that was information that came from the patient.

Q. Because it says UMR denied the claim on April 2, 2017 --

A. Yep.

Q. -- correct? And UMR was not the TPA for --

A. Correct.

Q. -- 2016 claims --

A. Yep.

Q. -- right?

A. Correct. But, again, that's -- that was the information he gave us so I can't say that specifically.

Q. Okay. All right. Back to Page 11, Number 4, Patient L.M. Is that Lucas Meyer?

A. It is.

Q. Tell me what was going on on this claim

or this patient.

A. Lucas Meyer -- Lucas Meyer used a service called Valley of Hope. And with this particular member there were -- it involved both covered and noncovered services. Valley of Hope has a -- a residential, if you will, and a -- a continuing care package. So in this situation Lucas Meyer had signed a -- a form indicating that if there were noncovered services that he would be responsible, so he signed a waiver.

Because specifically within the plan document it outlines -- it outlines that room and board is not a covered service. And so went through and identified letters that -- or the waiver that he had signed. Actually the facility provided letters to -- to him that actually he then -- I believe he sent it to Kutak Rock. I'd have to go back and check that specifically. But we were able to do a reconciliation to determine what the patient liability was, what the plan liability was and work through that and determine what he was responsible for, what the plan was responsible for.

Q. And Valley Hope, is that a drug and alcohol rehab center?

A. I believe it is, yes.

Q. And the total charges for the services were $12,628.53?

A. Correct.

Q. And then you have on Page 12, you say plan liability is $9,527.64.

A. Correct, yep.

Q. What -- how did you determine what the plan liability was?

A. Based on -- based on the covered charges, based on what the plan document said that it would cover, minus the member responsibility in terms of his -- he had a deductible there that he needed to cover and then also the patient liability -- yeah, his deductible was the 627.88, 793.01 was the coinsurance. And then there had already been a payment that had been made through TBG.

Q. So TBG had paid --

A. 1850.35.

Q. And do you know if that payment was made at the recommendation of AMPS?

A. I do not know that.

Q. So you don't know if this went through an RBR process --

A. I don't --

Q. -- review?

A. -- no. And then Lucas was responsible for the balance above what was paid by the insurance.

Q. Do you know whether this claim ultimately settled?

A. I do not.

Q. You had recommended a 20 to 25 percent discount?

A. Correct.

MS. BAUMERT: Can we go off the record for a second?

MR. THALKEN: Uh-huh.

(A discussion was held off the record.)

Q. Patient Number 5, is that Amy Eisenhauer?

A. It is.

MR. THALKEN: And that's E-i-s-e-n-h-a-u-e-r, for the court reporter.

Q. All right. So on Page 13, the middle -- or the second paragraph you say, The charge of 1350 was for an imaging service.

A. Right.

Q. Based on the prices published on the provider's website, the service was overpriced.

The provider had published prices on their website for similar imaging services for $499; correct?

A. Correct.

Q. So the provider was overcharging the plan.

A. Correct.

Q. For a service that they were advertising on their website cost $499, the provider was charging the plan 1350; correct?

A. Correct.

Q. And TBG you say had -- excuse me. You say that TBG had already paid $526.14; correct?

A. Correct.

Q. And that's a reasonable amount for that service in your view; correct?

A. Correct.

Q. But the provider wanted more money.

A. Correct.

Q. And balance billed the patient for $823.86; right?

A. Correct.

Q. And then you say, After some negotiating, Northwest Nebraska Imaging accepted $475 to resolve the outstanding balance.

A. Correct.

Q. So the total payments made on this $1,350

bill was $1,001.14?

A. Fourteen cents, correct.

Q. But that's more than the fair price.

A. Correct. The -- the -- the amount that was shown on their website was something that I had identified when I was reviewing the claim because I wanted -- when I reviewed the claim, I went in and looked at -- looked at their provider site because I wanted to understand -- I was looking for their place of service to determine what type of provider they are, because that too will affect the type of discount that they're willing to give, which is how I found the $499 price reduction.

Q. So at the end of the day, the plan saved about, call it, $350 on this --

A. Correct.

Q. -- claim? Did you spend more than an hour working on this claim?

A. Probably not.

Q. And you were charging $350 an hour; right?

A. Correct.

Q. Kutak Rock was also working on this claim?

MS. BAUMERT: Objection; exceeds the scope of the report, foundation,

form.

Q. Did Kutak Rock work on this claim?

A. I provided them information.

Q. Okay. Do you think that between your consulting fees and Kutak's fees, those fees exceeded the amount of savings ultimately achieved?

MS. BAUMERT: Same objections.

A. I don't -- I don't know the answer to that.

Q. You don't -- you don't think more than $350 in consulting and legal fees was spent on resolving this claim?

MS. BAUMERT: Same objections.

A. Yeah, I don't -- I don't know what that arrangement is.

Q. Well, you know what your arrangement is.

A. I do, but I don't know what theirs is.

Q. But you're charging $350 an hour.

A. Correct.

Q. And at the conclusion of all your work, the plan saved $350.

A. Correct.

Q. But your notes will show us how much time you actually spent on this claim.

A. Correct.
Q. Next one is 6, Patient J.L.
A. Uh-huh.
Q. Is that Jodi Lamprecht?
A. Yes.
Q. Tell me what you did with respect to her claim.
A. Jodi Lamprecht had -- she had multiple claims from numerous providers, and all of those -- all of the charges appeared to be for the same types of services. And in reviewing the claims, the first -- first task, if you will, was to sort out -- to attempt to sort out whether or not those claims were duplicate bills.

In the -- in the end, my determination was that there was potentially one duplicate claim, which is what I passed on to Kutak Rock in addition to the information relative to a potential discount range. However, I do know that it took considerable time to determine whether or not all of the claims that were submitted were for individual providers that -- that did, in fact, provide all of those services.

Q. And your ultimate recommendation was to seek a 40 percent discount?

A. Correct.

Q. Do you know how those claims -- or whether they settled?

A. I don't.

Q. If you'd look at Exhibit 192 on Page 3, there's two entries for Jodi Lamprecht. Do you see those?

A. I do.

Q. Are those the same claims referred to in your report?

MS. BAUMERT: Did you say two entries? There's three.

A. There's actually three.

Q. Well, one is Gary, isn't it?

MS. BAUMERT: Oh, yeah, 104. Sorry.

A. Yeah. The -- in terms of how these are rolled up under the Mercy Medical Center, they're -- a number of the claims that I reviewed would have rolled into Mercy Medical Center, which was part of the confusion, because the billings were from multiple providers, that while they had different tax ID numbers, the thinking was that they probably were employed by Mercy. So I suspect that the dollars all rolled into the Mercy Medical Center, which is why you only see two.

Q. Okay. All right. Next one on the bottom of Page 13, Patient 7 is patient L.J. Is that Lilly Johnson?

A. Yes.

Q. Okay. And Ms. Johnson had some care at Bryan Medical Center; correct?

A. Correct.

Q. And you recommended a discount of 20 to 25 percent off those billed charges.

A. Correct.

Q. Why only a 20 to 25 percent discount versus the 40 or 50 that you had mentioned earlier?

A. The -- the work that she had completed there was predominantly lab work. And there were other payments in looking at the other claims -- predominantly because it was -- it was for labs and it was consistent with other payments that they had made.

Q. And you stated then if you can't get a 25 percent discount, a 20 percent discount would be a reasonable discount; correct?

A. Correct, for the hospital outpatient.

Q. Now, on your date of service report for L.J. --

A. Uh-huh.
Q. -- are you there?
A. No, but I can get there.
Q. Okay.
A. Okay.
Q. There's four entries for Bryan Medical Center under L.J.; correct?
A. Correct.
Q. And they're all dates of service in -- between September 2016 and November -- or excuse me, December 2016?
A. Correct.
Q. Were you aware that CVA had entered into a settlement agreement with Bryan Medical Center in March of 2017?
A. Was not.
Q. Why would you be reviewing a claim that fell -- well, let me strike that and we'll start over.

(Deposition Exhibit 193 was marked.)

Q. Ms. Reed, I'm handing you what's been marked as Deposition Exhibit 193. And this is an E-mail from Rick Smithpeter to Natalie Skutt and Julie Maschka and Hannah Inman at The Benefit Group.

A. Okay.

Q. And it's dated March 8, 2017. Do you see that?

A. Yes.

Q. And Mr. Smithpeter writes, Please see attached direct agreement CVA has made with Bryan. We will want to do the same payment method as we did for Faith Regional whereas TBG will reprocess claims at 204 percent and send one check for all claims, then reconcile the amount owed by CVA and CVA will pay. And then he attaches an E-mail between Mr. Tim Meier, M-e-i-e-r, and Mr. Smithpeter. Do you see that on Page 2870?

A. Correct.

Q. And it says, Tim, please confirm. E-mail response is fine. Bryan agreement for 2016 claims, 35 percent discount of billed charges.

A. Yep.

Q. And then Mr. Meier responds, Yes, we are good with this. The only other item I would add is if we or you uncover another unpaid claim in 2016 that this same arrangement will apply. Thanks. Correct?

A. Yep. Correct.

Q. So does it appear to you that CVA had

reached an agreement with Bryan in March of 2017 to get a 35 percent discount off billed charges?

A. It does.

MS. BAUMERT: Objection; exceeds the scope of the report, speculation, foundation. You need to give me a minute.

THE WITNESS: Yep.

Q. So if CVA had an agreement with Bryan for 2016 claims that provided for a 35 percent discount and Lilly Johnson's claims were incurred in 2016, why were you reviewing this?

A. I reviewed it because Lilly Johnson's father, I believe it was father, contacted Kutak Rock on her behalf to request assistance in resolving an outstanding claim when they received an EOB and an invoice that they received from Bryan.

Q. Okay. But CVA and Bryan had already agreed to a 35 percent discount.

MS. BAUMERT: Objection; speculation, foundation, exceeds the scope of the report.

A. Bryan sent the invoice, and the explanation of benefits indicated it was outstanding.

Q. Well, you recommended a discount of 20 to 25 percent at a time that CVA already had a 35 percent contract.

A. I was not aware of that.

MS. BAUMERT: Objection; form, foundation, speculation, exceeds the scope.

Q. So CVA didn't tell you that it had an agreement -- a settlement agreement or a direct contract with Bryan for 2016 claims at a 35 percent discount?

A. I did not know that.

Q. Would you agree that CVA did better on its direct contract than the amount you recommended?

MS. BAUMERT: Objection; form, foundation, speculation, exceeds the scope.

A. Yes, the 35 is better than the 20 to 25.

Q. That you had recommended.

A. Correct.

Q. Now, look at Exhibit 192. On Page 2 there is four entries for Lilly Johnson. Do you see those?

A. I do.

Q. Are those the same claims that you reviewed?

MS. BAUMERT: Objection; form, foundation.

A. Yes.

Q. And according to Exhibit 192, for three of them the negotiator was Alison Gutierrez at Kutak Rock and for the fourth one it was Rick Smithpeter at CVA; correct?

A. Correct.

Q. Now, as I did the math, it looks like the settlement amount is a 34 percent discount.

MS. BAUMERT: Objection; form, foundation, speculation.

Q. Which is a lower discount than the settlement agreement that Mr. Smithpeter entered into in March of 2017; correct?

A. I would have to do the math but --

MS. BAUMERT: And I think you'd need to be --

THE WITNESS: Yeah.

MS. BAUMERT: -- able to read this. Do you want her to do the math?

Q. Well, we can -- we can do the math if you want. Let's do a hypothetical. I want you to

assume that the Lilly Johnson entries listed on Exhibit 192 add up to a 34 percent discount off billed charges.

MS. BAUMERT: Objection; form, foundation, speculation. You can't ask her to --

MR. THALKEN: I'm asking her --

MS. BAUMERT: -- assume that it's 34 percent.

MR. THALKEN: She's an expert, she can assume facts.

MS. BAUMERT: Assume about the math that you have in front of her that you're not allowing her to actually calculate.

Q. Do you need a calculator? Do you -- do you want to do the math, Ms. Reed?

MS. BAUMERT: You want her to do math in front of you?

MR. THALKEN: You just asked [sic] her that it's unfair if you don't. If you're not going to agree to my hypothetical assumption --

MS. BAUMERT: Why don't we take a break, Tim --

MR. THALKEN: Sure.

MS. BAUMERT: -- and let her do some calculations --

MR. THALKEN: Okay.

MS. BAUMERT: -- so that we're talking about apples to apples.

MR. THALKEN: Sure.

(A recess was taken from 11:34 a.m. to 11:44 a.m.)

Q. All right. Ms. Reed, have you had a chance to do the math?

A. I did.

Q. All right. What -- did you determine what the percent discount was on --

A. Thirty-five.

Q. Thirty-five percent?

A. Uh-huh.

Q. So the same discount as what the settlement agreement was in --

A. Correct.

Q. -- March of 2017?

A. Correct.

Q. So CVA paid you $350 an hour to review these and they paid Kutak Rock whatever their rate was to review these and they got the same discount

that was already in place.

A. Okay.

Q. Is that fair? I mean --

A. Yes.

Q. I mean, if the contract was for a 35 percent discount on 2016 claims at Bryan, wouldn't it have just been a matter of paying a 35 percent discount rather than having a law firm and a consultant involved?

MS. BAUMERT: Objection, form.

A. I don't know the answer to that.

Q. Number 8, Patient E.L., is that Long, the last name?

A. Yeah, Erica Long.

Q. All right. And this is a dispute with Hutchinson Regional Medical Center; correct?

A. Correct.

Q. And ultimately Hutchinson agreed to accept a settlement of 50 percent off the total billed amount; correct?

A. Correct.

Q. And they agreed to accept that discount even though there was no direct contract in place; correct?

A. Correct. It was a single case agreement

that was put in place between -- yes, a single case agreement was put in place.

Q. Next one is Patient 9, Patient S.B. is that Mr. Bechard, B-e-c-h-a-r-d?

A. Yes.

Q. Steven Bechard?

A. Yes.

Q. All right. And this was a dispute over a $689 invoice for an X-ray; correct?

A. Correct.

Q. And you recommended a 25 percent discount.

A. Correct.

Q. And looking at Exhibit 192, the first entry there for Steven Bechard -- first page of Exhibit 192.

A. Oh.

Q. Sorry. Is that first entry the -- the bill that we're talking about?

A. Correct.

Q. And it looks like, according to this, CVA paid -- just paid the $344.80. Well, let me restate. It looks like the full amount of the claim, $689.80, was paid.

A. Correct.

Q. So there was no discount earned on this

one.

A. Correct.

Q. And you consulted -- you put some time in on this one?

A. I did.

Q. And Kutak Rock put some time on this one?

MS. BAUMERT: Objection; speculation, form.

A. I provided my recommendation to them.

Q. Okay. So presumably they billed some time to this?

A. I would assume so.

Q. And the end result of all that work is there was no discount.

A. Well, the total amount was paid. Well, only the 344.80 was paid and the balance -- but the member was balance billed. So you could argue that the member provided the discount.

Q. Okay. In your experience is $689 a -- usually a reasonable and customary fee for an X-ray?

A. That is a reasonable fee for an X-ray.

Q. Next, Number 10. Is this Debbie Nelsen?

A. Yes.

Q. Okay. And looks like there -- on your

date of service report there are a number of entries on here. This one talks about an invoice from Oncology Associates --

A. Correct.

Q. -- is what -- do you know which invoice you're referring to in your date of service report?

A. I would have to look at it specifically. It is -- it's the invoice that showed 480 units.

Q. Do you know if this is a dispute over the $779.24 charge?

A. No. I -- I can't say for sure, but I believe it was much -- I believe it was higher than that. It was for 480 units of an oncology drug.

(Deposition Exhibit 194 was marked.)

Q. I'm going to hand you what's been marked as Exhibit 194. Can you tell from that document which bills these are? These talk about 480 units, but I don't know which one we're talking about.

A. This does show the 480 units. To get the actual dollars you have to take the 480 times the 873.60 --

Q. Okay.

A. -- to determine what they would actually

have to pay.

MS. BAUMERT: Maybe we should clarify what page you're on.

THE WITNESS: Oh, I'm sorry.

MS. BAUMERT: Down at the bottom, 302997. Tim was talking about 303005. So it's the second page of Exhibit 194.

A. Actually it's on each one of them. It's on 303 -- 3005. It's the first line to show you there -- it shows you dates of service. So she got 480 units on the dates of service 2-22-16 to 2- -- so that was a date -- when she came in on that date, she got 480 units. And that -- so that would have been the 873 times the 480. And then she came back in on 3-28, so these are weeklies that she's coming in for oncology treatments. So she'd have gotten 480 units each week when she came in.

Q. Okay. But to determine what the charge was, you'd have to -- you'd multiply 873.60 times 480?

A. Times 480. That's the cost of that drug.

Q. Okay.

A. Yep.

Q. And you wanted to verify whether she

actually got 480 units?

A. Correct, yeah. That was my question, was to say, before you do anything with that, before you pay it, make sure that she did, in fact, get the 480 units. So that would have been the cost associated with it.

Q. Did you -- did you actually verify that?

A. I didn't, but that would have been part of the negotiations.

Q. Okay. And the negotiations were handled by Kutak Rock?

A. Correct.

Q. And you weren't privy to those negotiations --

A. No.

Q. -- correct? Well, if I multiply $873.60 times 480, I get $419,328.

A. Right. So evidently when I look at what they did for this for the settlements based on their billing --

Q. What are you looking at right now?

A. I'm sorry. I'm looking at the -- Exhibit 192.

Q. Okay. Page 3 are you looking at --

A. I'm looking at Page 3 --

Q. -- Debbie Nelsen?

A. -- Debbie Nelsen.

Q. And this shows a claim amount of $2,850.61. Is that -- are we looking at the same thing?

A. We are. So I don't see where the claim payment is on this reconciliation.

Q. Looking back at Exhibit -- I'm just -- I'm a little confused because, again, my math is around $420,000.

A. Uh-huh.

Q. That would be a weekly charge? I mean, that seems --

A. Not unusual for an oncology drug --

Q. Really? Okay.

A. -- unfortunately.

Q. Okay. And that's what I'm trying to understand. Exhibit 194, when it says charges, is that really a multiplier or is that the actual total charge?

A. When you're dealing with -- the CPT code, when it says -- has a J in front of it, a J code is a drug code.

Q. Okay.

A. And so -- and when it says quantity for

that 480, that's typically what that -- what that means. Now, that's why -- but not everyone bills that in the same manner. So I know that, for example, some facilities will bill each unit separately and they will list every single -- like if you've got 480 units, you'll have 480 listed separately. So it -- you really have to go and ask the question, which was why --

Q. Uh-huh.

A. -- I said verify. Because it could be that there is a very small charge attached to that and it's only an admin fee that's being charged to administer the drug.

Q. Looking at the date of service report, I mean, there's nothing close -- close on Patient D.N. to a $400,000 charge; right?

MS. BAUMERT: I'm sorry. The date of service report --

MR. THALKEN: Yeah.

MS. BAUMERT: -- you mean 19- -- oh, that one --

MR. THALKEN: Yeah.

MS. BAUMERT: -- on her exhibit.

MR. THALKEN: On the back of her --

MS. BAUMERT: Yeah.

MR. THALKEN: -- expert report.

Q. I mean, as I look at this, the highest charge here is $44,944.75. I'm just trying to understand what you're looking at and how you're getting to the -- what the dispute was here.

A. Because the -- the date of service report --

Q. Well, I don't think we need to recreate this in this deposition but -- let's just, I think, move on, might be the --

A. I can't find what I'm looking for.

Q. Well, as I read Exhibit 192, on Page 3 there's an entry for Debbie Nelsen for $2,850.61. That's the claim amount. And according to this, TBG paid $2,071.37, leaving a balance-billed amount of 779.24, of which then CVA paid $587.30 to resolve it, if I'm reading this correctly. And I guess my question for you is, is Exhibit 192 on Page 3 when it talks about Debbie Nelsen, is that the claim that you were reviewing?

MS. BAUMERT: Objection; speculation, form.

A. I know the claim I reviewed had 840 [sic] units on it and it was for multiple weeks. I'd have to go back and look at the --

Q. Yeah.
A. -- individual claim I pulled.
Q. And I don't know that I've given you every document, so I don't want to be unfair here. I just -- I saw 480 on those and I didn't -- I didn't know if that's what you were relying on. But as I understand your testimony, we can't tell from the stuff I've given you at this point.
But -- but to my question on Exhibit 192, do you know if on Page 3 where it says Debbie Nelsen, $2,850.61, is that what you were reviewing in your report?
A. No, it's not, because --
Q. Okay.
A. Yeah. No, it's not.
Q. And how do you know it's not?
A. Because -- I guess, no, what I should say is I don't know for sure because I would have to compare that to the actual claims that I reviewed.
Q. Okay.
A. Yeah.
Q. Fair enough.
A. Yeah.
Q. At any rate, you recommended a discount of 20 to 25 percent off of the -- well, what is

that off of?

A. Average wholesale price, AWP.

Q. Well, you said for the drugs I recommended average wholesale pricing minus 25 percent. Above that --

A. Correct.

Q. -- you said, I recommended a discount in the range of 20 to 25 percent off billed charges.

A. Right, for administering the drug. Yep.

Q. So administering the drug, 20 to 25 percent discount; the drug itself, average wholesale price minus 25 percent.

A. Minus 20 to 25 percent, correct.

Q. Next entry, Number 11, K.D., is this Kim Duerke, D-u-e-r-k-e [sic]?

A. Correct.

Q. Tell me what you did on this patient.

A. On this one I actually did very little. This patient sent in an EOB indicating that they had a credit balance of this 1467.74. I looked through the outstanding claim files that -- that we had and -- to see if I saw anything that was owing. I didn't see anything and so essentially said the way it looks, there is a credit balance of the 1467.74. And unless a provider submits a

bill, it looks like there's a credit balance.

Q. So this one had been processed correctly in your view?

A. I really couldn't tell. I didn't have enough information to know one way or the other.

(Deposition Exhibit 195 was marked.)

MR. THALKEN: Megan, this is CVA 302477.

Q. So I'm handing you, Ms. Reed, what's been marked as Exhibit 195. And is this the E-mail you were referring to when it said K.D. sent Kutak Rock an explanation of benefits indicating she had a credit of 1,467.74?

A. Yes.

Q. Okay. And then the second page --

A. Yep.

Q. -- of that is the EOB; correct?

A. Correct.

Q. And it shows employee's responsibility is zero dollars.

A. Correct, yep.

Q. And the plan payment, it shows a credit of $1,467.74.

A. Correct.

Q. And this member wanted to determine if

that credit amount to the plan was correct?

A. Correct.

Q. And so you -- Kutak Rock spent time figuring out -- well, sending this to you; correct?

A. Correct.

Q. And how much time did you spend reviewing this?

A. Half hour to an hour at the most.

Q. Okay. So -- and you're charging $350 an --

A. Yes.

Q. -- hour --

A. Correct.

Q. -- to tell the plan member that the plan is owed a credit?

A. Correct.

Q. And Kutak Rock is billing legal fees to confirm that the plan is owed a credit?

MS. BAUMERT: Objection; form, foundation.

Q. Do you think that's the best use of the plan's funds, to spend money on a law firm and a consultant to confirm that the plan is already owed a refund which is what had been reported to the plan?

MS. BAUMERT: Objection; form, foundation, exceeds the scope of her report.

A. There may have been a provider bill to cover this.

Q. But you don't know of one.

A. No, but I was looking to answer the question the member asked.

Q. And you were charging for your time to do that because -- I mean, usually if I get something in the mail that says I'm owed a refund, I don't hire a law firm and a consultant to verify that the refund is owed. I mean, is that normal?

MS. BAUMERT: Objection; form, foundation, exceeds the scope of her report.

A. We were simply trying to respond to the member.

Q. And this member, she was not balance billed.

A. Simply trying to respond to the member's question.

Q. And the member didn't say, hey, I've been balance billed; right?

A. The member's question was, can you tell

me what this is. And we're trying to respond to that.

Q. Okay. And so at $350 an hour, you tried to respond to the member's question that, hey, I got an EOB that says the plan is owed $1400. Can you verify that the plan is owed $1400?

A. I believe --

MS. BAUMERT: Objection, form.

A. -- I answered the question.

Q. Is that what you did?

MS. BAUMERT: Form.

A. I believe we did.

Q. And you confirmed that, in fact, the plan was owed $1400.

MS. BAUMERT: Form.

A. Correct.

Q. And how much money did it cost the plan to determine that it was owed $1400?

A. I don't know the specifics of that.

Q. More than $1400?

MS. BAUMERT: Objection --

A. I don't know.

MS. BAUMERT: -- form, foundation.

Q. Number 12, looks like there's two patients here. G.S., is that Gary Sipe?

A. It is.

Q. And S.R., is that Shelby Rahe, R-a-h-e?

A. Correct.

Q. Okay. And these are both claims with Via Christi Health System?

A. Correct.

Q. You state in here, It was difficult to find a person to work with at Via Christi.

A. That's correct.

Q. What did -- what do you mean by that?

A. It was just -- it was difficult to get in touch with an individual that would -- that you could talk with that had the authority to do any kind of negotiations. As you went through their billing office, the first response was, we don't negotiate. Then when you asked to speak with a supervisor, if you got passed to a supervisor, the supervisor wouldn't call back.

And so finally I was asked to try and make contact with individuals I had worked with there previously. And so I actually ended up making contact with a colleague of mine to try and get some assistance to try and work through some kind of a single case agreement.

Q. Okay. And looking at the bill, you

recommended a discount of 60 to 65 percent; correct?

A. Correct.

Q. Did you think that the bill was -- that the hospital was overcharging for the services?

A. I did think the bill was high. And I also understood that from a health system perspective and the size of the hospital that I did not think that was an unreasonable discount.

Q. Sixty to 65 percent was not unreasonable?

A. Correct, due to the size of the facility.

Q. How big is Via Christi?

A. Via Christi is a -- I can't speak to their -- to the total revenue. I can tell you as a health system, they are one of the larger health systems within the region, in the Kansas City region.

Q. So this wouldn't be a rural hospital.

A. No, it's not.

Q. Okay. If you want to flip over to Exhibit 192, and let's look at this. Are any of these claims for Gary Sipe -- looks like there's one maybe on Page 4, I'll direct your attention to, for Via Christi.

A. Yes.

Q. And is that -- is this the claim you were reviewing?

A. I don't have the specific dollar amounts written down, but I believe that it is, yes.

Q. If you look at your date of service report on the back of your expert report, there's an entry there for September 26, 2016, for date of service --

A. Yep.

Q. -- for --

A. Correct.

Q. -- $33,089.34? And does that match -- that doesn't match.

A. It doesn't match.

Q. Yeah. That's the same date of service; right?

A. It is the same date of service; it is the same claim. I may have just recorded from a different spot on the claim. It is the same claim.

Q. Okay. And so of the amount billed, the 36,000, TBG had already paid 18,000?

MS. BAUMERT: I'm sorry. 36,000?

MR. THALKEN: I'm looking at the -- Exhibit 192.

MS. BAUMERT: And what page are you

on? I'm sorry.

MR. THALKEN: Page 4.

A. TBG had paid the 18,053.25?

Q. Yes. So that would be about a 50 percent discount?

A. Correct.

Q. And your -- your opinion is that a discount of 60 to 65 percent would be a good discount.

A. Correct.

Q. And TBG had paid 50 percent.

A. Uh-huh.

Q. Is that a yes?

A. Correct.

Q. And then CVA on top of that paid another $11,181.65 to settle the claim; correct?

A. Correct.

Q. It would be significantly less than 60 to 65 percent.

A. Yes.

Q. Would you assume for a moment that the $18,000 payment made by TBG was done at the recommendation of AMPS. Okay?

You're calculating something here. What's --

A. I am. Excuse me just a minute.

MS. BAUMERT: You're asking for percentages.

A. Uh-huh. Okay.

Q. What did you just calculate there?

A. What I -- what I was calculating was the percentages in terms of the amount that was balance -- balance billed in relationship to the -- to the amount of the discount that both TBG had gotten for the amount of the claim that the -- the discount that was given and the amount that the -- that -- essentially the member responsibility.

Q. And what were those --

A. And --

Q. Well, okay.

A. I didn't keep them. But when I look at the member responsibility and I look at -- yes, TBG did calculate just over -- you know, close to a 50 percent discount, but the member picked up a large percentage as well. So had we gotten closer to that 60 percent percentage, the member would have had a much smaller percentage that they would have had responsibility for.

Q. So what would a 60 percent discount on billed charges be?

A. That would have increased that by another -- another $8,000. Did I do that right?

Q. Well, let me ask you another question.

A. Yeah.

Q. If CVA had gotten a 60 percent discount off the billed charges, that would be a payment of $22,013.60.

A. Right.

Q. And TBG had paid 18,053.20.

A. Uh-huh.

Q. And then CVA on top of that paid another $11,181.65.

A. Right.

Q. So CVA didn't get a 60 percent discount on this; isn't that true? CVA didn't get a 60 percent discount?

A. That's correct.

Q. But the $18,000 payment that TBG did make, was that reasonable for the charges?

A. Yes, I mean, that's a good discount. I don't disagree with that.

Q. Okay. And then S.R. is the next one within this group --

A. Uh-huh.

Q. -- Shelby Rahe?

A. Yes.

Q. And I'll refer you to Exhibit 192, Page 3. Shelby Rahe, Via Christi, do you see that entry?

A. Tell me again what page we're on.

Q. Yeah. Page 3, it's the second from the bottom. There's a Shelby Rahe.

A. Right, yep.

Q. Is that the claim you reviewed?

A. It is.

Q. Okay. And it looks like the dispute on this claim was over $474.13 out of total billed charges of $13,868.98?

A. Correct.

Q. And ultimately it looks like CVA just paid the full amount of the balance bill?

A. Correct. And the decision to do that was because -- the thinking was that if that one were paid, that there would have been a better outcome on the -- on the Gary Sipe's case.

Q. Kind of treat them as a package deal sort of?

A. Correct.

Q. But on that one you still -- after paying the additional 474, there was still a significant discount off that --

A. Correct.
Q. -- bill.
A. Yes.
Q. Over 30 percent; right?
A. Correct.
Q. Next one, 13, Patient T.G., is that Terry Granfield?
A. Yes.
Q. Okay. And you say, T.G. is part of the CHI claim negotiations.
A. Uh-huh.
Q. Kutak Rock asked that I validate the negotiated rate being offered by CHI to ensure it meets the intended 195 percent of Medicare. The rate being offered is in the form of a DRG payment.
A. Uh-huh.
Q. I expect to be able to make that verification within the next week.
A. Correct.
Q. So a DRG payment, is that a diagnosis-related group --
A. It is.
Q. -- payment?
A. Correct.
Q. And what's a DRG -- what does that mean

in laymen's terms?

A. Essentially it's a case rate, so it's for a specific period of time for an inpatient stay. Remember when I talked earlier about the APC payment for outpatient? A DRG is the same type of thing only for inpatient. That case has since been resolved.

Q. Okay. How was it resolved?

A. I provided information back to Kutak Rock indicating that the calculations were -- met the -- met the -- met what they were looking for.

Q. What calculations are you talking about?

A. They were the intended 195 percent of Nebraska Medicare.

Q. Okay. So at some point CVA entered into a direct contract with CHI in which claims were paid at 195 percent of Medicare?

MS. BAUMERT: Objection, form and foundation.

A. I don't know the answer to that.

Q. Okay. Well, when you talked about the negotiated rate being offered by CHI to ensure it meets the intended 195 percent of Nebraska Medicare --

A. That was an agreement of some form

between CHI -- with CHI. I can't speak to the specifics of that.

Q. Okay. You don't know if it was finalized or not --

A. Exactly.

Q. -- but you were --

A. Right.

Q. It was your understanding though that there was a deal in the works, if you will, at 195 percent --

A. Correct --

Q. -- of Medicare.

A. -- yep.

Q. All right. And this one will be difficult. Might need your help, Michaelle. So same exhibit, Exhibit 192, there's an Attachment C. And about nine pages from the back of Exhibit 192 -- it looks like that (indicating).

A. So it's after these --

Q. It's nine from the back. So start at the back and go nine.

A. Okay.

MS. BAUMERT: So this one there are four yellow --

MR. THALKEN: Yeah.

MS. BAUMERT: -- highlighted entries, Terry Granfield, Randy Kelly, Terry Granfield, Randy Kelly. You can just look at mine if you want.

THE WITNESS: Okay. All right. I'll look at yours. All right. I'll stop sorting.

MR. THALKEN: That's fair enough.

Q. So there's an entry on the page for Terry Granfield. Do you see that?

A. I do.

Q. Is that the claim you were reviewing for him?

A. 41,000, yes.

Q. Okay. And then if you'd look at the next page, it looks like it goes on, if you want to flip the page. There's some notes in there, 195 percent of Medicare per TBG. Do you see that? $7,855.32?

A. Uh-huh.

Q. Is that a yes?

A. Yes.

Q. Then there's CHI notes, DRG 236. What does that mean?

A. Every -- every case, if you will, based

on the severity of the case is assigned a number by Medicare. And that tells you the -- the weight, if you will, attached to that inpatient stay.

Q. Okay. So did you do this spreadsheet?

A. I did not.

Q. Okay. Do you think the $7,855.32 is the accurate number for 195 percent of Medicare?

A. I'd have to calculate it to check that.

Q. So how does the DRG work versus 195 percent of Medicare?

A. The way that works is that Medicare assigns a -- Medicare assigns a weight. Are we talking this specific claim?

Q. In general, I think. I just -- I don't fully understand --

A. All right.

Q. -- the DRG process versus 195.

A. Every -- every case starts at a weight of one, and so -- and then from there the DRG severity works up. So then the DRG is based on its weight, so your conversion factor is then multiplied times the weight assigned to that case. So -- and your Medicare rate -- so it's your Medicare rate times the weight.

So let's say I have a DRG at a weight of one at $10,000 for an inpatient hospital stay. And then there's a weight attached to -- in this case it was DRG 303, all right, which is a cardiac surgery. So that weight is something greater than one so then you're going to take my $10,000 times 195 percent. So it's 95 times greater than one. And that's how you're going to get 195 percent of Medicare.

Q. Okay. You never saw the settlement agreement or the direct contract with CHI though.

A. Did not.

Q. So you don't know if there's a DRG provision in it or not.

A. I don't.

Q. Fourteen. Yeah, go ahead.

A. To be accurate though, I want to make sure that what I'm stating is accurate. On the last claim that I did review, that is what I was looking for, was the 195 percent of Medicare for that claim.

Q. And that's the Granfield claim that we're talking about?

A. Correct.

Q. Fourteen on your report.

A. Yes.

Q. You talked about Kutak Rock negotiating with CHI?

A. Correct.

Q. You weren't actively involved in the direct negotiations; correct?

A. I was not. Typically what would happen is if there was a case they were negotiating on, I would be consulted on occasions that says we have lab cases that we're reviewing and here's the approach we are planning to take. Does that seem reasonable? And -- so that was really the extent of it.

Q. Okay. Let me go back to 13 before -- you said, I expect to be able to make that verification in the next week. You did --

A. I did complete that. That is complete now.

Q. Okay. And then is that --

A. Yes.

Q. -- did you just talk to Kutak Rock about it or what did you do?

A. Correct, yes.

Q. Is there any document about it or --

A. I passed back the same form that they

gave me and explained the numbers that were on the form.

Q. Okay. Did you create any spreadsheets regarding the CHI 195 percent --

A. Did not --

Q. -- figures?

A. -- no.

MR. THALKEN: I believe those are all the questions I have. Thank you.

THE WITNESS: Okay. You're welcome.

MS. BAUMERT: Let's take a quick break.

(A discussion was held off the record.)

(A recess was taken from 12:32 p.m. to 12:45 p.m.)

DIRECT EXAMINATION

BY MS. MITCHELL:

Q. Ms. Reed, my name is Megan Mitchell; I represent AMPS and CDS in this matter. I want to go back to some of your prior testimony about experience with RBR plans. And when I say RBR, you understand that to mean reference-based reimbursement; correct?

A. Correct.

Q. Have you worked with an RBR plan since

2004, or was that the last experience that you had with -- with an RBR plan?

A. That is my last experience in terms of working with one.

Q. Okay. Are you aware of the differences in various types of RBR products?

A. Yes, I am.

Q. Can you explain what you mean?

A. I understand -- my understanding with an RBR product is that contracts -- contracts do not exist with providers, that what is paid to a provider is considered usual and customary for services that are rendered to a member, and that if the provider does not accept that as full payment, then the members are balance billed.

Q. And is it your understanding that it would be the hospital's decision whether to balance bill a member; correct?

MS. BAUMERT: Objection; form, foundation.

A. I do understand it's the hospital's decision; however, there is not a hospital that won't balance bill.

Q. On all of the claims that you've reviewed then for these 14 patients, you understood that

they had all received a balance bill; correct?

A. I can't -- I can't speak to that because I didn't review the entire -- the entire situation. All I reviewed were individual claims.

Q. So some of these patients may not have received a balance bill then?

A. I don't -- I don't know that specifically.

Q. Okay. And I believe you said that as your understanding of RBR works, a contract with a hospital does not exist. Is that your testimony?

A. Yes, it is.

MS. BAUMERT: Objection; form, foundation, exceeds the scope.

Q. So is it your understanding that if a plan adopts an RBR program, there would not be direct contracts with hospitals prior to adoption of an RBR program; correct?

A. (Witness nodded head.)

MS. BAUMERT: Objection; form, foundation, exceeds the scope of her report. You're going to have to answer. She definitely can't hear you when you're nodding.

A. That -- that's my understanding.

Q. That no direct contracts are in place

prior to implementing an RBR plan; right?

MS. BAUMERT: Same objection.

A. Correct.

Q. And do you have any familiarity with RBR products in Nebraska as of 2015 or 2016?

A. I do not.

Q. Are you aware that there are at least eight groups that are using RBR programs in Nebraska working with AMPS and TBG currently?

A. I'm not aware of that.

Q. So you didn't talk to any of those groups about their experiences with RBR as part of the scope of your expert report in this case?

A. I did not.

Q. Are you aware that some claims that AMPS handled for CVA were done in the 2015 plan year?

MS. BAUMERT: Objection to the form.

A. The claims I reviewed were 2015, 2016 and then run-out for 2017.

Q. Okay. Did you understand that CVA was a participant in a traditional PPO network for the 2015 plan year?

A. Yes, I did.

Q. And did you understand that CVA contracted with AMPS to provide medical bill

review services for the 2015 plan year?

A. Yes, I did.

Q. Did you review the MBR agreement as part of your expert report?

A. Yes. Yes, I did.

Q. And did you review the MBR -- the MBR agreement while you were looking at claims that had a 2015 date of service?

MS. BAUMERT: She's saying MBR.

A. By MBR, do you mean medical bill review?

Q. I do, yes.

A. Okay. I did not review that while looking at claims.

Q. Okay.

MS. MITCHELL: And if someone has a copy of the exhibits that have previously been marked in this case, the MBR agreement has previously been marked as Exhibit 16. Is someone able to show that exhibit to Ms. Reed?

MR. THALKEN: Yes, we have it. Okay. It's in front of her.

Q. So, Ms. Reed, is this -- is this a copy of the MBR agreement that you looked at in connection with your expert report?

A. Yes, it is.

Q. Okay. So if you look at Section 2.4 of the MBR agreement, do you see that?

A. I do.

Q. And it says, Client shall give AMPS full authority to act on its behalf during the various stages of an appeal of a claim payment reduced based on a recommendation by AMPS and continuing through the finalization of such appeal. Do you see that?

A. I do.

Q. Did you ever review that language in connection with your recommendations made to the plan in connection with this case?

MS. BAUMERT: Objection; asked and answered, form.

A. I did review that prior to reviewing claims and indicated that I thought it was problematic and language that should cause great concern to the employer and to the plan.

Q. And why is that?

A. Because it abdicates the plan's responsibility to an outside third party. And the employer is -- and the plan, excuse me, as a self-funded plan are ultimately responsible for

the dollars that get spent.

Q. So is it your opinion that the plan violated a duty by engaging AMPS to perform medical bill review?

MS. BAUMERT: Objection; form, foundation, exceeds the scope of the report.

A. I'm not talking about abdicating responsibility. I'm talking about the best interest of the plan.

Q. I'm not sure I understand your answer. You said -- I believe you testified earlier that the plan abdicated its responsibility by giving responsibility to a third party.

A. No, I don't believe --

Q. I'm trying to understand your answer.

A. I don't believe I said that they abdicated responsibility. I said I didn't believe it was in their best interest to allow someone else to have full authority.

Q. And did you read Section 2.5 of the MBR agreement which says that if for any reason client does not allow AMPS to conduct and control an appeal that contests a recommended reduction by AMPS, there will be no adjustment to the fees paid

to AMPS for its review of the claim, and it goes on. Do you see that language?

A. I do.

Q. So is it your understanding that the client could make its own decision on an additional payment amount?

MS. BAUMERT: Objection; form, foundation.

A. I do see that.

Q. And did you take a look at Attachment A to the MBR agreement? Are you familiar with this Attachment A?

A. Yes. I'm looking at it right now.

Q. Did you look at Attachment A when you were making recommendations on any of the claims for the 14 patients that we've talked about today?

A. I did not.

Q. When did you look at Attachment A?

A. I looked at Attachment A when I reviewed the medical bill review document in the very beginning of my engagement.

Q. Was that prior to the lawsuit being filed in this case?

MS. BAUMERT: Objection; form, foundation.

A. I can't speak to that specifically. It would have been in sometime mid to late September.

Q. Of what year?

A. Actually it would have been early October -- October 9th of '17.

Q. Okay. So you first looked at this document in October 9th of -- on or around October 9th of 2017.

A. Correct.

Q. And do you see Paragraph A that discusses percentage of savings, fees and compensation?

A. I do.

Q. So did you understand that CVA was retaining 70 percent of the savings on any claims that AMPS reviewed?

MS. BAUMERT: Objection; form, foundation, exceeds the scope of her report.

A. I do understand that.

Q. And that if -- if a claim is subsequently successfully challenged in the appeals process by the provider and a higher adjusted charge is recommended by AMPS and paid by client, then upon receipt by AMPS of verification of such payment and a copy of the applicable revised or

supplemental explanation of payment, AMPS shall credit or reimburse TPA for the account of client for such proportionate amount of percentage of savings fees previously paid or currently due to AMPS. Do you see that in Section B?

A. I do.

Q. So did you understand that CVA would receive a refund on AMPS's savings if it complied with Paragraph D?

MS. BAUMERT: Form, foundation, exceeds the scope of the report.

A. I -- I do see these provisions. My review of this document was -- was not for the purpose of making an evaluation about the specific terms that the two organizations had set forth but, rather, to look at a type of arrangement that an employer typically has in place, the type of partnership an employer typically has in place with a third-party administrator for a self-funded plan.

Q. Okay. So when you were looking at a claim with a date of service of 2015 later on after October of 2017, did you discuss with Kutak Rock or anyone else the provisions on Attachment A to the MBR agreement?

MS. BAUMERT: Objection; form, foundation, scope of the report.

A. I did not.

Q. And then for the vast majority of the claims that you looked at, they had dates of service in 2016; correct?

A. Correct.

Q. As you were reviewing these claims, did you look at the plan document for 2016?

A. Yes, I did.

Q. When did you look at the plan document?

A. I looked at the plan document as I was reviewing specific claims to determine whether or not there was a -- something was a covered service.

Q. Did you look at the permitted payment levels adopted in the plan document?

A. I did. Specifically there was a case that dealt with maximum payment amounts for prescription drugs, and that is noted in my -- in my report. It's for -- I'll have to -- let me check here to see which member. It's actually on Page 10 of my report for the -- for the first patient where it talks about the pharmaceutical payments and there being restrictions relative to

what the calculations need to be limited to.

Q. Okay.

MS. MITCHELL: And if I could have someone show Ms. Reed Exhibit 8 that has previously been marked in this case.

A. Yes.

Q. Ms. Reed, is this Exhibit 8 a copy of the plan document and summary plan description that you reviewed as discussed on Page 10 of your report?

MS. BAUMERT: I think she's going to have to look at it to see.

MS. MITCHELL: Sure.

Q. And if it helps, on the very last page of this exhibit, it appears to have been signed by Tim Esser on January 19th, 2016.

MS. BAUMERT: I will say, Megan, that she identifies in her report a Bates number, CVA 1, as where her -- where the plan document began in her report. So, as you know, there are sometimes several iterations of the same document, and the document is produced by each party. And the one that you're pointing to is a TBG marked document.

MS. MITCHELL: Sure.

A. And I -- I don't have with me the complete document sum- -- summary plan document that I reviewed. I do have a portion of it with me. The cover page is the same, but beyond that I can't say specifically it's the exact document. So I guess I would refer you to the reference in my report.

Q. Okay. Thank you.

In the portion of the report that you have with you of the plan -- I'm sorry. Do you have Page 42 and 43 of the plan document?

A. I do not. I go to Page 30.

Q. So you don't have anything after Page 30?

A. Not with me.

Q. Okay. Do you have Page 4 of the plan document?

A. I do.

Q. Do you see a provision that says balance billing?

A. I do.

Q. Do you see that that provision says, Again, the plan has no control over any network provider that engages in balance-billing practices, except to the extent that such

practices are contrary to the contract governing the relationship between the plan and the network provider. Do you see that?

A. I do.

Q. Did you review that provision of the plan document in connection with your work on this case?

A. I did.

Q. When did you review this provision?

A. I can't say specifically when I reviewed it. I do know I reviewed it because I have it circled.

Q. Okay. And does that provision of the plan document -- is it reflected in any of your expert opinions in this case?

A. It -- it is not because it -- it's not.

Q. So you didn't rely upon this provision in forming any of your expert opinions in this case?

MS. BAUMERT: Objection; asked and answered, form.

A. In my -- in my expert opinion I do speak to balance billing, and I speak to that -- I reference it in the -- the sixth from the bottom sentence on Page 6. And I also referenced it on Page 7 under Letter B.

Q. Was it -- is it your opinion that any hospital that balance billed a patient was acting in violation of the plan document?

MS. BAUMERT: Objection; form, foundation, exceeds the scope of her report.

A. I was not connecting the two.

Q. Do you have an opinion on that sitting here today?

MS. BAUMERT: Objection; form, foundation, exceeds the scope.

A. Can you ask that question again?

MS. MITCHELL: Would the court reporter mind reading that back, please?

(The last question was read by the court reporter.)

A. The provider has no tie to the plan document or to the plan because they have no contract. So there would be nothing to be in violation of. I mean, they have no relationship with you.

Q. So is it your opinion that any of the terms of the plan document don't govern payment made by the plan to providers?

MS. BAUMERT: Objection; form,

foundation, exceeds the scope.

A. They have no relationship with you, they have no contract.

Q. I would like for you to turn to Page 42 of Exhibit 8.

MS. MITCHELL: And, Michaelle, also the CVA 0001 document that I have is not a copy of the plan document. So unless you have that in the room, I'll use Exhibit 8.

MS. BAUMERT: Okay.

A. Okay. I'm on Page 42.

Q. Do you see the permitted payment level provision at the bottom of the document?

A. Yes, the last -- yep. The last sentence there?

Q. Right. And if you flip to Page 43, the plan document shows that the permitted payment level for inpatient covered services shall be based upon 160 percent of the Medicare allowable IPPS amount for the covered services or, if greater, 135 percent of the cost of the covered services. Do you see that language?

A. I do.

Q. Did you review this language in

connection with any of the 14 patient claims that you reviewed in this case?

A. I did not.

Q. Did you review this language at any time?

A. I -- I can't say specifically. Yeah, I can't say specifically that I did.

Q. So you don't have any recollection of reviewing this language on Page 43 of the plan document then.

A. I don't.

Q. Okay. And then if you turn to Page 70 of -- of Exhibit 8, the plan document.

A. (Witness complies.) Okay.

Q. There's a provision called basis for benefit adjustment at the bottom of the page. Do you see that?

A. I do.

Q. There's language there that says, The claims delegate may, in its sole discretion, increase reimbursement for allowable expenses included in such hospital or facility claim by up to 30 percent of the amount of the permitted payment levels set forth above. Do you see that?

A. I do.

Q. Did you review this language at any time

when you were making recommendations on claims for the 14 patients discussed in your expert report?

A. I did not.

Q. Have you reviewed this language at any time?

A. I -- I cannot -- I can't recall if I did or not.

Q. So you don't have any recollection of reviewing the language in this basis for benefit adjustment provision --

A. I don't.

Q. -- in the plan.

A. I don't.

Q. So if you read this language now, I understand that you may not have seen this before, but looking at the basis for benefit adjustment language and turning back to the permitted payment level provision on Page 43 of the plan document, this appears to allow payment at up to 208 percent of Medicare on a hospital or facility inpatient claim. Would you agree with that?

MS. BAUMERT: Objection; form, foundation, exceeds the scope.

A. So you're saying the 180, plus at the discretion an additional 30.

Q. The 160 plus the --
A. Or I'm sorry.
Q. -- additional 30.
A. That's a 60?
MS. BAUMERT: Yeah, that's 160.
THE WITNESS: Okay.
MS. BAUMERT: And she's asking you whether 160 plus 30 --
A. 160 and 30 is 190; right?
Q. Thirty percent of 160.
A. Ah, okay.
Q. And add that on to the 160.
A. Okay.
Q. Does that equal 208 percent?
MS. BAUMERT: Objection; form, foundation, scope.
A. It would.
Q. That's just a math question.
A. Yeah, yeah. Yes.
Q. Okay. So in connection with any of your work on this case, did you ever evaluate whether a payment was made below or above 208 percent of Medicare?
A. I -- I did not. But I can tell you that in looking at the 195 percent, most of my

recommendations were above that because a number of the facilities that -- where care was delivered are rural facilities. And most of them, even for Medicare, are recognized as -- as facilities that cannot take -- that are entitled to additional payments.

Q. Okay. And 204 -- 208 percent is higher than 195 percent of Medicare; correct?

A. Correct.

Q. And that's -- that is the amount that CVA agreed to pay the CHI hospitals. Is that your understanding?

A. Correct.

Q. Okay. Can you turn to Page 75 of Exhibit 8, please.

A. (Witness complies.) Okay.

Q. Do you see the section entitled Assignment?

A. I do.

Q. Okay. And if you look at the third paragraph under Assignment, do you see the language that says, Any provider who has accepted assignment of benefits and/or payment of benefits from the plan and then pursues recovery from the claimant, on any legal or equitable theory, shall be acting in violation of this plan and shall be

required to immediately refund in full any and all amounts paid to such provider by or on behalf of the plan in connection with the claim in question. Do you see that?

A. I do.

Q. Did you review this language in connection with any of the recommendations that you made on claims involving the 14 patients that are discussed in your expert report?

A. I did not.

Q. Did you review this language at any other time?

A. Not that I recall.

Q. Are you aware of whether anyone advised the plan to seek a refund of any and all amounts paid to any provider that balance billed a patient?

A. Not -- I don't know.

Q. Okay. Did you ever recommend to Kutak Rock or to the plan that it should enter into any direct contract?

A. Yes.

Q. Can you tell me about that recommendation?

A. There were two situations where direct contracts were considered. One of them was with the -- for Patient Number 8, Erica Long, at

Hutchison [sic] Regional Medical Center. We also then for Via Christi, however, that one did not come to fruition.

Q. So for patient E.L. -- when you say a direct contract, do you mean a single case agreement?

A. A single case agreement, yes.

Q. Okay. So you're not referring to a direct contract between the CVA plan and the provider that would govern claims other than that single claim.

A. Correct. We -- yes. In each situation that I referenced, they were single case agreements, they were not ongoing direct employer and -- employer and plan contracts.

Q. Did you have any involvement at all in recommending that the plan enter into any direct contracts between the employer group and the provider?

A. I did not.

Q. I want to understand who you spoke with about the recommendations that you made on the claims in your expert report. Other than Kutak Rock, did you speak with anyone at CVA about your recommendations?

A. I did not.

Q. Okay. So you only spoke with Kutak Rock.

A. That's right.

Q. And I know we've talked about this a little bit, but you didn't have any understanding of whether a patient -- one of the 14 patients in your report had received an invoice or a balance bill as opposed to a collection notice as opposed to a lawsuit; is that right?

A. Only if the patient referenced it in the material that they sent.

Q. So otherwise you had no idea of the status of the claim in terms of whether it was an invoice all the way up to a lawsuit.

A. Correct.

Q. Would that information change the way you would evaluate the claim?

A. I -- I don't -- I don't think so.

Q. So for purposes of the recommendations that you made, it didn't matter whether the patient had just received an invoice from the hospital as opposed to whether the patient had received -- had been named in a balance billing lawsuit. Those cases should be treated equally. Is that -- is that what I understand you to be

saying?

A. Not necessarily, because there were times when a patient received -- their bill had been turned over to the -- to a collection agency. And so the -- the recommendation would be to -- rather than go to the collection agency, to still contact the hospital to do those negotiations and attempt to negotiate with the hospital rather than the collection agency.

Q. So is it your understanding that there were times that a collection agency notice was not responded to?

A. When you say not responded to, are you talking about not responded to by the patient or -- I'm not sure I understand.

Q. Well, I'm only asking you what you know. So you said that you were aware of an -- of instances where a patient would receive a collection notice, but you or others acting on behalf of CVA would contact the hospital, not the collection agency; is that right?

A. That would be my recommendation. I can't tell you if that was the way that it went.

Q. And why would that be your recommendation?

A. Because if -- in my experience if you're

able to negotiate still directly with the hospital, you can avoid the fees that a collection agency would pay if you can get the hospital to pull that account back from the collection agency.

Q. Was -- it would be possible for the collection agency to pursue a lawsuit if no one responded to the collection agency though; right?

A. Well, I -- I suspect. I mean, it's pure speculation, but I -- I doubt that they were ever left totally hanging.

Q. And what makes you say that?

A. Because the -- the member did not come back with a follow-up situation asking for assistance.

Q. And did you ever try to evaluate in the situation where a collection notice was received whether the collection agency had actually purchased the debt from the hospital as opposed to just collecting a debt on the hospital's behalf?

A. Did not.

Q. Okay. Are you aware that there's -- that that difference exists?

A. Yes, I am.

Q. Did you ever -- have you ever spoken to anyone at AMPS in connection with your

recommendations made on claims in this case?

A. Have not.

Q. Have you ever spoken with anyone at AMPS ever?

A. No, not that I'm aware of.

Q. Have you ever spoken with anyone from CDS in connection with your work on this case?

A. Again, no, not that I'm aware of.

Q. Have you ever spoken with anyone from CDS ever?

A. No.

Q. Did anyone ever give you any instruction about whether to contact AMPS or CDS about any of the claims that you reviewed in this case?

A. No, they did not.

Q. Did it ever occur to you to contact AMPS or CDS about these claims?

A. No. I mean, I didn't have a reason to.

Q. Are you offering any opinion on whether AMPS or CDS handled a claim incorrectly?

A. I'm not.

Q. So you -- you do not have an opinion that AMPS handled any claims incorrectly in this matter.

A. That really was not the scope of my

engagement.

Q. Okay. So -- and it is -- so you are not expressing the opinion that AMPS handled any claims incorrectly in this case.

A. I -- yeah, I did not review for that.

Q. And so you're also not expressing an opinion that CDS handled any claims incorrectly in this case.

A. Again, I didn't review for that.

Q. And the scope of your review was to determine what additional amounts should be paid on the claims that you reviewed?

A. That and to validate that the claims submitted were accurate.

Q. As submitted by the hospital; correct?

A. Right, the hospitals or other providers.

Q. Okay. And so it wasn't the scope of your review to determine whether a claim was paid in a manner inconsistent with the plan document then.

MS. BAUMERT: Objection, form.

A. Occasionally, yes. If there was a noncovered service that was being billed for, I would identify that so that those charges were not -- were not paid for if they were member liability.

Q. I see. So you looked at the plan document to determine whether a hospital was attempting to recover on an inappropriate charge.

A. Correct. And if you look at patient -- Valley of Hope.

MS. BAUMERT: L.M.?

THE WITNESS: Yes.

A. If you look at Patient L.M., I think he's like Number 4.

MS. BAUMERT: He is.

A. Yeah, he's Number -- Patient Number 4, Lucas Meyers [sic]. You'll note that that's a combination of both covered and noncovered charges in that claim review.

Q. Right, I see that. But you were not reviewing claims to determine whether they were -- they had been previously paid in a manner that was inconsistent with the terms of the plan document; right?

MS. BAUMERT: Objection, form.

A. I mean, it was -- it was kind of all simultaneous.

Q. Right. And I'm just trying to figure out whether you were looking at the amount that had been previously paid on these claims to determine

whether those amounts were paid in accordance with the terms of the plan document.

A. So -- so, yes, I did look at amounts that had been previously paid, depending upon when the billing came in. So it was that total episode of care that I reviewed.

Q. Did you ever question the amount that had previously been paid on the claim? That's what I'm trying to get at. I understand that that was part of determining what additional amount, if any, should be paid. But did you ever reach the conclusion that the amount that had previously been paid was incorrect for any reason?

A. I did not.

MS. BAUMERT: Objection, form.

Q. Okay. Do you have any understanding of how a percentage of Medicare would relate to the prevailing PPO rate for plans in Nebraska?

MS. BAUMERT: Objection; form, foundation, scope of the report.

A. Yeah, it's difficult to -- it's difficult to say as a percent of Medicare because it's -- very few contracts that I'm familiar with in Nebraska are written as a percent of Medicare.

Q. And so if -- if a general discount for a

PPO contract is 25 percent off of billed charges, for example, do you have any way of determining how a 25 percent discount off of billed charges might relate to a percentage of Medicare?

MS. BAUMERT: Form, foundation, scope of the report.

A. Yes, with some -- you know, with some time you can back into that. I mean, it's -- but, I mean, you need to have some other numbers to be able to do that. It's just -- you need volumes and --

Q. So when that --

A. You need volumes and --

Q. I'm sorry. Go ahead.

A. You need volumes and you need -- you need weights and you need to know whether it's inpatient or outpatient. It's not -- it's not a simple calculation, 20 percent discount equals X percent of Medicare.

Q. Sure. So, for example, with the CHI agreement that was done at 195 percent of Medicare --

A. Uh-huh.

Q. -- do you have any understanding of what the PPO rate might be with CHI, for example, to use as a comparison?

A. I do not.

MS. MITCHELL: I think that's all I have. Thank you.

THE WITNESS: Okay. Thank you, Megan.

MS. VOGT: I have just a few, and mine are kind of from the macro level.

THE WITNESS: Okay.

DIRECT EXAMINATION

BY MS. VOGT:

Q. When you were working with Kutak Rock, would they contact you about a specific claim and then you give them a recommendation and then they deal with the hospital to try and get that result?

A. Uh-huh. Typically they would send me a list of claims that needed to be reviewed or a list of individuals that needed to be reviewed, and then I would start to review the correspondence and the claim files and then provide updates on those as I finished my reviews. And then they would have the communication back with the respective providers.

Q. Did you review claims other than the ones that are addressed in your report?

A. Did not.

Q. Were you ever provided with the results that Kutak actually achieved?

A. I did not.

Q. Do you do the same kind of consulting for other plans, examining claims and making a recommendation?

A. I do on -- on occasion, not -- not in the exact same manner. I do it -- I've done it more for audit purposes where employers have asked me to come in and audit claims to be sure that they're being paid according to contracts and being paid appropriately.

Q. So more of a reconciliation?

A. More of a reconciliation. And then -- yeah, I would say it's probably more of a reconciliation.

Q. When you do that, is it in conjunction with an attorney or just administrators?

A. Can be both. Depends on the reason why the employer is asking for it.

Q. What things did you take into consideration when you looked at each one of these claims?

A. I took -- I took into consideration the place of service, so where -- where it was billed, because that -- there are specific billing

requirements as a -- if you're a hospital, a clinic, an outpatient center, if you're a stand-alone outpatient center. So there's a specific code, place of service 11, place of service 21, 22. So I took that into consideration.

Then I looked at the CPT codes so -- to be sure that the service that was provided matched the CPT code that was billed. If there were pharmaceuticals that were provided, then I looked at the J codes and I -- I actually looked up the drugs that were provided to make sure that the -- essentially the -- the charges that were being provided were reasonable given the cost of drugs these days. Then made sure that those billings for those were appropriate.

Oftentimes, if there were multiple providers that were involved, I looked to be sure that -- that there weren't duplicate charges similar to the one that I mentioned in the Sioux City market. Then from there I essentially reconciled to be sure that they -- the billing was accurate. From there, then depending upon what each particular member was looking for, investigated that particular claim to try to get

to the resolution. So, you know, were they looking to see is this something that I owe? I would sometimes do the reconciliation on what had already been paid, what's the member's deductible, had that been satisfied?

So it would be a matter of going back and reconstructing what had been billed, what had been paid and what the remaining balance was. And then based on that, depending upon the service that was -- it was outstanding on, would make a recommendation back to Kutak Rock how they would -- or what they could try and obtain for a discount.

Q. And I -- it appeared to me from your report that the majority of your recommendations fell somewhere between 20 percent and 60 percent.

A. That's correct.

Q. What were the main factors that would make a difference between a 20 percent recommendation --

A. Uh-huh.

Q. -- and a 60 percent?

A. It would -- it would fall into a couple of different categories. One of that would be place of service. Another would be type of

provider. And the -- the last one would be then the -- type of service, the provider type, and then the other would be the service -- the service itself. So if it's -- for example, on the oncology drugs, I happen to know -- or when you're dealing with drugs in particular, I happen to know that there's a large markup. If you're dealing with imaging services, imaging services are a very profitable -- imaging and lab are very profitable services within a hospital setting, as are outpatient services. Those are very profitable areas so typically you can have a larger discount there.

If you're dealing with physician services, in physician services you'll typically see around a 40 to a 45 percent discount. In a hospital setting, a lot of times you'll see somewhere around that 50 percent mark. Again, it depends upon the size of the group and it depends upon whether or not that's a direct contract, size of the group. And so all of those things get taken into consideration.

Q. Towards the beginning of your testimony you said that the health care group that you used to work for --

A. Uh-huh.

Q. -- refused any claim from TPAs trying to use reference-based reimbursement.

A. Correct.

Q. Do you recall if those programs were based on a percentage of Medicare?

A. No, they were -- they were based on usual and customary.

Q. And do you know how they were determining usual and customary?

A. I -- that was part of the issue, was that you couldn't really tell. What you were told is that it's based on usual and customary, but it was difficult to really understand what usual and customary meant because that meant something different to really just about every third-party administrator.

Q. You also had mentioned that an RBR program puts an employer at risk.

A. Yes.

Q. Tell me how it puts an employer at risk.

A. I believe it puts an employer at risk because in today's market -- and, again, this is my opinion, in today's market when you have a difficult time hiring employees, I think that one

of the things we have to sell are our benefits. And the -- an RBR program, because it puts members and their families in a position where there is balance billing and oftentimes that can create financial strain for a family, I believe that that disadvantages an employer when they're trying to hire.

I also think that while it can create savings for an employer on the short-term, I do believe that over the long haul that there will be -- that there will be costs that they will incur through -- whether those will be costs on the -- on the pharmacy side, on the medical management side because they are not as involved in managing their plan.

Q. Were you aware that in -- in the case of the CVA plan that CVA had the ultimate authority to accept or reject the recommendations for payments?

MS. BAUMERT: Objection; form and foundation, exceeds the scope of the report.

A. I was not.

Q. You mentioned that you worked with some employers and you had rejected reference-based

reimbursement and worked with the employers to get like on a short-term plan?

A. Correct.

Q. Do you know if any of those employers sued their TPAs?

A. I don't know that.

MS. BAUMERT: Objection, form and foundation.

Q. Did you do any review to see if -- if the claims you were looking at were a duplicate of claims that had already been reviewed by somebody else?

A. Did not.

Q. And in your review -- in the claims that you looked at, did you see any that the materials in the file you had showed that the claim had already been paid?

MS. BAUMERT: Objection, form.

A. Are you saying that there was a delinquency notice?

Q. No. I'm saying in any of the claims that you reviewed, did it appear that that claim had been submitted more than once?

MS. BAUMERT: Objection.

Q. In other words, that it had a duplicate.

MS. BAUMERT: Form, foundation.

A. Oh, only the one that I mentioned in the Sioux City situation.

Q. You said something about even Medicare recognizes there are facilities that are entitled to additional payments.

A. Uh-huh.

Q. Would you explain to me?

A. Yes. There are facilities that are classified as critical access facilities, such as your smaller facilities. And so they put in place what's called cost-based reimbursement. So if you are classified as a critical access facility, you're paid at 105 percent, is typically the minimum payment that you receive.

Also, if you are a rural facility and you're classified as such, there is a rural -- there's a rural factor that is applied. For example, on the fixed outpatient reimbursement that I was describing early on, your conversion factor is increased by 1.5 percent. So if your -- you know, if your rate's a hundred dollars, you're going to get an additional 1.5 percent on every procedure that is performed.

Q. And early on you were talking about -- I

can't remember exactly how you phrased it, but basically that if you didn't have a contract with a hospital it would be hard to get them to discount a bill --

A. Uh-huh.

Q. -- is that correct?

A. That's correct.

Q. In this case there were, in fact, many instances of the claims that you worked on where a discount was received.

A. Uh-huh, that's true. There are -- there are some facilities that will accept something other than what they've billed. I can -- I can say that that is not a sustainable practice for those facilities, particularly facilities that are -- that are small in nature. And I -- that's one of the reasons that I believe that contracts are important, and over the long term I think it's important, again, that you have that kind of a relationship and that facilities understand what it is that they're going to get paid and that it does become more of a partnership arrangement between employers and providers relative to how health care is delivered. Because if we are ever going to get our arms around what health care

costs, we need to figure out how to do it together as opposed to creating what, I believe, is some kind of an adversary relationship where we simply decide what we're going to pay each other and not sit down and have that conversation. So we need to create opportunities where we bring one another together to figure out how we make the system better as opposed to just exchanging dollars at whatever rate I decide I'm going to exchange those dollars.

Q. And before you started your consulting business, you worked for a provider --

A. I did.

Q. -- is that correct?

A. I did. I actually worked on both sides of the house, as we said. I worked on the provider side where I negotiated all the contracts to determine what it was that the hospitals and the physicians were going to get paid. And then I ran the health plan where I worked with the employers. And so did I, yes, try to make sure that when I was negotiating with the insurance companies that I kept those discounts as low as I possibly could, I did that for a number of years.

And then I changed that practice so

that instead of trying to work to get just a better reimbursement, I worked to put risk-based contracts in place so that I could create a situation where the payer, the ultimate payer, the member, the employer, and the provider came together through direct contracts and you treated the TPA like they should be treated, and that is someone who pays a claim.

Q. And I -- I'm not sure I understood what you said the first time about risk based. Was what you were saying is if the hospital is very prompt in getting their billings out --

A. Right.

Q. -- they are rewarded by being paid the full amount, whereas if they hold something for a long time that might be reduced? And if that's not right, just explain it to me.

MS. BAUMERT: Form. I'm going to make an objection as to form, and I didn't hear that at all so --

A. I don't remember that.

THE WITNESS: Can you --

MS. BAUMERT: She would have to go back --

THE WITNESS: Yeah.

MS. BAUMERT: -- to the beginning of the transcript to look.

A. Is there something you can reference in the report that might help?

Q. Well, you said -- it was on Page 3, the fourth dot down from the time -- or from the top. And --

A. Oh, okay.

Q. -- Mr. Thalken asked you --

A. Right.

Q. -- about risk-based and what you said at least --

A. Yes. Okay.

Q. -- in part in my scribble --

A. Uh-huh.

Q. -- was if provider met a standard for promptness, they got full dollar amount; if longer, maybe not.

A. Okay. So this is in relation to a risk-based payment methodology. Okay. So in that instance, there is a set dollar amount that you're going to get paid for a particular procedure. And in that case there's -- there are assumptions made about what resources you're going to use, say, how long I'm going to be in the -- in the operating

room, how many supplies are going to be used, okay, so what the total resource consumption is going to be. And so if I stay within those parameters, then I'm going to either -- I'm going to make money on that payment or maybe even come out a little bit ahead. But if I use more resources than what it is assumed when my payment was put together, then I'll lose money on that transaction.

Q. Okay. So just so I understand --

A. Uh-huh.

Q. -- the hospital sets a per procedure cost.

A. Correct.

Q. But if it takes much longer or they need to use many more supplies than --

A. Correct.

Q. -- a normal one, they're not going to get paid for the extra.

A. No -- correct. They're going to get paid whatever that agreed-upon amount is. And if it costs more than that, they're not going to get paid for it.

Q. Okay. I understand now.

A. Okay.

MS. VOGT: I think that's all of my

questions.

MS. BAUMERT: I just have a few just to clear things up.

CROSS-EXAMINATION

BY MS. BAUMERT:

Q. So when you were talking about dealing with the RBR pricing systems in the late '90s and the 2000s, that was when you were with Avera.

A. Correct.

Q. And none of those RBR pricing structure type arrangements that you were dealing with were in Nebraska; right?

A. Correct.

Q. And then we've been talking about RBR programs and your opinions with regard to RBR programs. And when you were speaking about them not being in the interest of the employee or the plan or the employer, you were contemplating RBR means no advance direct contracting; correct?

A. That's correct.

Q. And so if there is an RBR arrangement -- and I think some of this is semantics about RBR and what we all think of RBR in this case --

A. Uh-huh.

Q. -- and what you think --

A. Right.

Q. -- of RBR. If there is an advance direct contracting element to an RBR program, you wouldn't necessarily call it an RBR program --

A. That's correct.

Q. -- right? But we would here --

A. All right.

Q. -- in this case, this life. So if there is direct contracting relationships as an element of that and if there's an understanding on behalf of the plan and the employer that those are going to be put into place, then that would be sort of a different opinion.

A. That would be a different opinion.

MS. MITCHELL: Object to the form. This is Megan Mitchell.

MS. BAUMERT: We know.

MS. MITCHELL: I'm the only one on the phone.

A. Yeah, if -- if there are, in fact, contracts, then you're right, that is different. But as you noted, I mean, that to me -- when you say RBR, to me that -- that means there are no contracts. But I understand in your context if there's a contract in place, yes, that does change

the -- the outcome.

Q. Right. So if an employer is contemplating an RBR arrangement with a third party like AMPS or CDS, for instance, and understands that there will be direct contracting as part of it, you would consider that to be exercising their due diligence on behalf of their plan.

A. Correct.

MS. MITCHELL: Object to the form.

Q. And then we talked a little bit as well about Exhibit 192 and we were talking about Gary Sipe. He's on Page 3. And you had been doing some clickety-click calculating?

A. Uh-huh, yes.

Q. And we kind of started talking about things with the plan, what the member obligation was to pay and then we stopped talking about that. I just wanted to make sure that that testimony was complete --

A. Okay.

Q. -- because you had said that the member paid more. What -- what would the member -- what would Gary Sipe have paid? That's what we mean; right?

A. Correct.

Q. Okay. So what would Gary Sipe have paid on this -- this claim here that we have at the top of that page, Page 4?

MS. VOGT: Object to the form.

MR. THALKEN: Foundation.

A. The calculations that I were doing is that I took a look at the charge of the 36,689. Yes, TBG did obtain a discount and took that and paid the 18,053. And -- however, the member was balance billed 18,636. So, in essence, the member paid almost the same amount as what was -- the discount amount that TBG obtained.

So if you look at what CVA paid, in -- in a typical arrangement -- and, again, I'm making some assumptions. In a typical arrangement, that 18,636 would have been split between the amount that TBG would have -- would have had on the negotiated side for the provider and what CVA, what the employer would have done. So in -- in my world with a contract, Gary Sipes [sic] would have paid -- overpaid by 20 percent because those additional dollars would have been covered by the employer and the provider.

Q. Okay.

MS. BAUMERT: I don't think I have

any further questions.

MR. THALKEN: Couple follow-ups on that, Ms. Reed.

REDIRECT EXAMINATION

BY MR. THALKEN:

Q. So with respect to Gary Sipe when you're looking at Exhibit 192 --

A. Uh-huh.

Q. -- you don't know whether Mr. Sipe made any payments on this.

A. Correct. He may have ignored the amount that was balance billed.

Q. Right, right. It's a balance-billed amount but it's not a paid --

A. Correct.

Q. -- amount; correct? And CVA paid 11,186.65 [sic] to resolve the claim out of the 18,000 balance bill. Is that your understanding?

A. That's correct.

Q. Okay. You testified about critical access facilities, and I think you said cost-based reimbursements were paid at 105 percent?

A. Correct.

Q. 105 percent of what?

A. 105 percent of their cost.

Q. Okay. Is that different than 105 percent of Medicare?

A. It is. There's a separate reimbursement system for critical access facilities.

Q. Okay. You asked about -- or I think you testified about long-term -- there are long-term costs --

A. Uh-huh.

Q. -- because the employer is not as involved in managing the plan --

A. Right.

Q. -- something to that effect? I didn't quite understand what you mean by that.

A. What I mean by that is if you look at -- if you look at pharmacy spend today, which will -- pharmacy costs for a health plan today or for a -- for an employer today, it's not uncommon for that to represent 40 percent of an employer's spend today. And that continues to rise because of specialty drugs. So if an employer -- and, again, it's about attracting and retaining high quality employees. If you're not a part of how those -- how your plan is offering those kinds of benefits, then from a financial perspective you'll find yourself in a position where you may not be able

to continue to offer that kind of benefit or be as competitive.

Now, you may not be offering a -- a pharmacy benefit, in this situation they are, but you might have to find that you have to drastically reduce that. I believe that an employer who offers a health plan benefit to their employees needs to be involved with that, needs to understand what their employees are getting for that benefit and then needs to be able to use that as a tool to recruit and retain.

Q. Did the RBR program apply to prescription drug costs?

MS. BAUMERT: Are we --

A. No, it's more really about kind of the overall benefits that it can offer.

Q. And I'm asking about in this situation -- I mean, you mentioned prescription drugs. Is it your understanding that the RBR program applied to prescription drug costs?

MS. BAUMERT: I think -- haven't you kind of finished your questioning? Aren't we kind of jumping on a new line of questions here?

MR. THALKEN: No, I'm following up

what she said.

MS. BAUMERT: Following up what she said to their questions, not --

MR. THALKEN: Right.

MS. BAUMERT: -- to my questions. So I don't understand where we're going with the scope of this. Now we're like reopening it and everybody is getting another turn again?

MR. THALKEN: It's my deposition, direct examination, cross-examination.

MS. BAUMERT: And redirect which --

MR. THALKEN: And now I'm redirecting.

MS. BAUMERT: -- is supposed to be based off of my cross.

MR. THALKEN: And their cross.

MS. BAUMERT: No, not their cross. You're all on the same side.

MR. THALKEN: Well --

MS. BAUMERT: That's not the same thing.

MR. THALKEN: -- we're here.

Q. Can you answer my question?

MS. BAUMERT: Well, I'm objecting

to this entire line of questioning so --

A. And I may have used an inappropriate example.

Q. So -- but you don't know whether prescription drug costs in this --

A. I don't.

Q. -- case were subject to RBR.

A. Correct. I don't know.

MR. THALKEN: That's all I have.

MS. BAUMERT: All right. You have the right to read and sign the deposition --

THE WITNESS: Okay.

MS. BAUMERT: -- if you would like to do so to make sure your testimony is recorded accurately.

THE WITNESS: Okay.

MS. BAUMERT: You have to in our jurisdiction say on the record whether you would like to read and sign it or whether you waive that right. We've been recommending that people read and sign in this case because it's --

THE WITNESS: Okay. I will read and sign.

MS. BAUMERT: -- so complicated and there are lots of acronyms.

THE WITNESS: I will read and sign.

(The foregoing deposition was concluded at 2:00 p.m.)

STATE OF NEBRASKA )
:ss
COUNTY OF DOUGLAS )

ERRATA SHEET

I, JEAN REED, do hereby attest that I have read the foregoing deposition and find it to be true and correct, with the exception of any changes that I have noted below:

| PAGE | LINE | CHANGE/REASON FOR CHANGE |
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If you make no changes, please indicate NO CHANGES.

JEAN REED

Subscribed and sworn to before me this _____day of _____, 2019.

GENERAL NOTARY PUBLIC

CERTIFICATE

STATE OF NEBRASKA )
:ss
COUNTY OF DOUGLAS )

I, Tina M. Nelson, Registered Merit Reporter, and General Notary Public in and for the State of Nebraska, do hereby certify that JEAN REED was by me duly sworn to testify to the truth, the whole truth, and nothing but the truth; and that the deposition as hereinbefore set forth was reduced to writing by me and is a true and accurate transcription of the testimony given by said witness;

That the within and foregoing deposition was taken by me at the time and place herein specified and in accordance with the within stipulations, the reading and signing of the witness to the deposition having not been waived;

That I am not counsel, attorney or relative of any of the parties or otherwise interested in the event of this suit;

IN TESTIMONY WHEREOF, I have placed my hand and notarial seal this 7th day of March, 2019.

_____
Tina M. Nelson, RMR
General Notary Public

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

| | |
|---|---|
| CENTRAL VALLEY AG COOPERATIVE and CENTRAL VALLEY AG COOPERATIVE HEALTH CARE PLAN, Plaintiffs, | CASE NO. 8:17CV379 |
| vs. | COST CERTIFICATE |
| DANIEL K. LEONARD, SUSAN LEONARD, THE BENEFIT GROUP, INC., ANASAZI MEDICAL PAYMENT SOLUTIONS, INC., d/b/a/ ADVANCED MEDICAL PRICING SOLUTIONS, CLAIMS DELEGATE SERVICES, L.L.C., and GMS BENEFITS, INC., Defendants. | |

* * *

I, Tina M. Nelson, RMR, do hereby certify that on February 22, 2019, I took the deposition of JEAN REED on behalf of the defendants in the above-captioned case, that said deposition was transcribed and delivered to Mr. Timothy Thalken, defendant TBG counsel; that the total costs of the deposition to be assessed to the defendants are in the total amount of $_____.

Dated this 7th day of March, 2019.

_____
Tina M. Nelson, RMR
General Notary Public

## B

## Q



## R

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## V



## W

## X



## Y



## Z